Health Care Cost Trends Hearing

6-29-11 AM

Seena Perumal Carrington

...and I welcome you to the third day of the Division's public hearings on health care cost trends. I don't know about you, but I'm pretty happy that we're at the halfway point now. Two days left! So I'm Seena Perumal Carrington, Acting Commissioner of the Massachusetts Division of Health Care Finance Policy and Chair of these hearings. I'm joined today by Assistant Attorney General Susan Brown. For those of you joining us for the first time, welcome, and for those of you who have attended the prior two days, I appreciate your stamina, and a special thank you to all of you! I want to begin by recapping some of the highlights for Monday and Tuesday.

So on Monday, Governor Patrick and other key state officials reminded us of the extraordinary leadership and commitment we have from both the administration and the legislature to tackle the intensifying challenge of health care cost growth, and to develop strategies that will lead to lasting, meaningful change in the health care delivery system. Next, the Division of Health Care Finance and Policy and the Attorney General's Office

summarized the key findings from our recent analyses of health care cost trends in the Commonwealth. The results of this analysis are available on the Division's website where there's a special section devoted to these proceedings.

Yesterday we shifted our focus to a key issue identified in both the Division's and the Attorney General's analyses; that is, the role of increasing prices as a key factor in driving rising private health care spending. We examined in further detail the wide variation in prices paid to providers for the same services. In the ensuing panel discussions there was near universal agreement that the extent of price variation is a challenge that needs to be swiftly addressed, but there were differences in opinion on the best course forward. There was universal agreement, however, that transparency alone was not sufficient to impact utilization patterns.

Today we're going to continue our examination of specific factors underlying rising health care costs by shifting our focus to two new challenges. In 2009 the Special Commission on the Health Care Payment System unanimously recommended moving away from a fee for service system which rewarded volume over value, yet the Division's recent analysis found that relatively few private health care services were financed through

[capitated?] payments in 2009. In the morning, therefore, we will discuss alternate payment methodologies. We will start with a presentation of analytical findings from both the Division of Health Care Finance and Policy and the Office of the Attorney General. The Division will present the findings of our recent efforts to model the savings impact of bundle payments. This is new data that hasn't been released yet. Next, we will hear expert witness testimony from Harold Miller, Executive Director of the Center for Health Care Quality and Payment Reform, on how better payment systems can help improve health care quality and control costs. We will conclude this session with a response panel of various stakeholders sharing their experiences with alternate payment methodologies. We're then going to break for a short 30 minute lunch and reconvene promptly at 1:00 pm, where we will shift our focus to yet another challenge, and that is the need for better health resource planning. Starting with a presentation of analytical findings from the Division, we will specifically discuss the Agency's recent analysis of total medical expenses by geographic region and primary care access and supply in the Commonwealth. Next, we will hear expert witness testimony from Cathy Schoen, Senior Vice President of the Commonwealth Fund, on thinking creatively about the health care system we need for the 21st century. We will conclude with a response panel of various stakeholders discussing how we can

better anticipate health care needs and appropriately match resources with those needs. Similar to yesterday, panels will be sworn in and will be providing their testimony under oath. While the moderator will ask the majority of questions, Susan or I may intervene at any point if we wish to dig further into an issue, but all of you are also encouraged to engage with ideas being shared. There are index cards available in your folder. Please write any questions that you may have for panelists and give them to members of my team who'll be walking around. At the end of each panel the moderator will ask some of the submitted questions.

So ultimately, based on the information presented today, Monday, and Tuesday, the Division is charged with developing a final report with recommendations. I appreciate that this is a lot of information to absorb in a few short days. I ask for your patience and time. If we're ever to address health care costs, we need to have more of these thoughtful community discussions that are informed by data. It is the Division's role to cut through jargon and rhetoric, to separate anecdote from data from fact, and to ensure that policy discussions are based on trusted, reliable analyses, and it's a role that we take seriously. And so at this time, then, I'd like to officially begin by inviting Stacey Eccleston, Assistant Commissioner for

Health Care Finance and Policy at the Division, to speak. Thank you, Stacey.

Stacey Eccleston:

Thank you. So this presentation just looks at one of the many options or alternatives for a different method of payment, the bundled payment model from Prometheus, not to endorse bundled payments over other types of arrangements, such as global arrangements, or to endorse this particular model of bundled payments, but as a way to understand what the potential savings is using this example. The software was available to us and the claims data was available to us.

I've often heard from others that the Prometheus model is pretty complicated, and I'm not going to lie, it is a little bit complicated, but as we were working through trying to sort of unravel and get our heads around it, we really got a better understanding of what it was doing conceptually and what it was doing in reality, and I hope that I can shed some light on that for you today. I'll have to admit, though, some of the technical details of the application we haven't quite mastered, so we're fortunate enough to have a representative from HCI3 here, and

she’ll join me during the question and answer session, and her name is Jenna [Kosley?]. So let’s start with some of the concepts first.

A bundle payment basically reimburses a provider or a group of providers for the provision of multiple services that were delivered during a defined episode of care, that are typically paid on a fee for service basis now, and instead paid on a lump sum. The key, of course, is how to arrive at that single fee. If it’s just a total sum of what the historic fee for service payments were, there really doesn’t seem a point there. Rather, it’s an arriving at a fee that is something that’s appropriate to reward the delivery of quality care while containing costs associated with care that might be outside of what we think of as best practices for the particular condition. The episodes are either acute, so one time events, or they can be chronic, and the services include all of the clinically related services, such as the hospital admission, if there is one, the ambulatory care, pharmaceuticals, and other clinical and professional services. They cover typically a defined period of time, like a year, for example, for any of the chronic conditions, or a pre and a post surgery period for the acute positions. So the idea here is to contain costs while at the same time improving the quality of care that’s delivered to the patients.

So there’s several methodologies currently that are publicly available -- Geisinger model applied in a fully integrated system, the baskets of care for Minnesota, some federal government models that are out there, and the Prometheus model that we’ll be discussing today -- but they’re all pretty common in the approaches that they take. They all have the dual goal of achieving better quality for the patient while at the same time containing or lowering the total cost for the care. The better quality and the lowering of the cost is achieved by creating incentives to reduce what are potentially avoidable complications of the care. We’ll refer to them as PACs throughout this presentation. Providers are generally explicitly or implicitly rewarded for delivering high quality care, explicitly through receiving bonus payments for meeting certain quality thresholds, and implicitly through the reduction of readmissions and other adverse events, the PACs, which allows the provider, then, to retain more of the money that’s paid for the single episode. The bundles can be designed and implemented either prospectively, where provider groups receive full payment sort of upfront, or retrospectively, where claims are paid sort of in a traditional way, and then at the end there’s a reconciliation against what the total cost target is. And while it’s likely easier to implement bundle payments in a fully

implemented system, it’s also possible to do so in a less integrated system.

So the Prometheus model defines two different types of risks: payers continue to assume the full financial responsibility for the cost of the typical episode, as defined by best practices, and for the severity and the complexity of their particular member population, as well as the individual patient’s condition, because these severity differences are built into the payment, and that’s the probability risk. But the provider assumes the risks, the technical risks for the costs that are associated with the adverse events, or the PACs, and we’ll talk more about those in a minute. The basic approach of the Prometheus model is that the payment is determined as an evidence-informed case rate. We’ll refer to that as the ECR, and we say evidence-informed because it’s based on both treatment guidelines, established treatment protocols, as well as expert opinion from providers that depicts the best practices for treating the certain conditions that it covers. The evidence-informed case rate, the ECR, is equal to the average cost of the typical care, as defined by those treatment guidelines, plus a severity adjustment specific to the patient, plus a margin that’s built in to cover some portion of the provider’s overhead cost and infrastructure, and plus an allowance, a proportion of

an allowance for the potentially avoidable complications. A PAC is simply defined as something outside of the typical care that we receive, so it’s beyond the best practices treatment code of protocols and things like that result in readmissions or other such events.

The total ECR that is developed is paid to all providers providing the episode of care, regardless of whether PACs are, in fact, involved. So how does that save money? Well, since the PAC is calculated as an amount that’s less than what the full cost of PACs have been, it rewards providers that have the quality performance, and those that do have PACs will lose money, and that’s realized in systems savings, and they’ll lose more money depending how many PACs were involved. The system cost savings then are achieved through the nonpayment or the reduced payment for those PACs, for services that are outside of the typical care. The actual formula and the percentages for the margins in the PACs can be negotiated between the payer and the provider. For our purposes, for the model that we’re using, we use a 10% margin amount, and roughly about a 50% PAC allowance, and that’s pretty standard in the model, but those adjustments can be made.

So we still need to -- I break this down, I think. So the evidence-informed case rate basically sums the four factors: the base cost associated with the typical care -- and remember, typical care is all the services that are determined to be needed to care for this particular condition in a quality way. The covered services are determined by those commonly accepted guidelines. Then we add to that the severity adjustment for that particular patient based on the acuity of the patient, plus the margin -- in this case we're talking about 10% -- plus the PAC allowance, which is in our model at about 50% of the historical PAC costs that are associated with the chronic conditions. Providers can also be eligible for a bonus from the PAC pool if their performance meets a set quality threshold. We're not factoring in that piece into this model here. So basically the ECR, the evidence-informed case rate, is equal to the base cost plus the severity adjustment plus the margin plus the PAC percentage.

So let's look at the actual data, and here we're going to use pneumonia as an example, and this is based on our 2009 claims data that we have, so these are actual numbers for Massachusetts. The average cost of the typical care that's determined to be in the best practices related to the treatment of pneumonia is $6,072. This particular patient that we're going

to use has a typical severity, so he's not older, there are no co-morbidities, so just an acuity that's similar to the average acuity of the patients population, so $0 are added for that. The margin here is 10% of the severity adjusted typical cost of the care, so $607. The PAC allowance is $578 for what is a flat fee portion, and since the rate of PACs for this particular, for pneumonia is 29%, there's a proportional rate, 29% times the severity adjusted typical care, for a total PAC allowance in this case of $2,339. So you add those together, and for pneumonia in 2009 we have a total evidence-informed case rate, for this patient, Patient A we'll call him, for pneumonia that's $9,018.

So the payment for Patient A's pneumonia will be the same, regardless of the provider, so it all depends on what the provider actually spends as to how it turns out. Providers will gain or lose depending on what they experience in terms of actual expenses. So our Patient A has an ECR of $9,018 for the cost of care related to this acute pneumonia episode. In scenario one -- so we'll walk through three different patients -- so in scenario one with Provider A, that provider evidently incurred some adverse events that resulted in actual expenditures for this patient for the entire episode of nearly $18,000, so nearly $9,000 over the ECR. That money is lost to

the provider and is part of that provider risk we talked about earlier, the risk associated with adverse events. Provider B here -- and Provider B here actually represents what we found in the data to be the average cost of care -- incurred expenses that were $3,898 over the computed ECR. So -- and Provider C had expenses that were closer to what the actual cost of the typical care was determined to be, so about $7,000, an efficient, high quality provider. That provider got a bonus in payment of about $2,000 over and above the $7,000 that he or she incurred during the care for this patient because the ECR is $9,000. As I said, that middle bar represents the system savings, because on average across all of the providers in the total expenditures for all care, including the PACs for pneumonia that we found in our 2009 data was about $13,000, but the calculated ECR was $9,000, so average savings of about $3,898 for that one patient. That savings comes out of the providers with severe adverse events and gets somewhat redistributed to those with minimal or no adverse events, and the rest is system savings, in this case the $3,898 for this one patient.

So the episodes that are currently part of the Prometheus model include both chronic conditions such as asthma, diabetes, hypertension, as well as acute conditions. They include inpatient procedural, such as orthopedic hips and knees, [CABG?]

in bariatric surgery. They include inpatient medical procedures, such as AMI, pneumonia, and stroke, and outpatient procedures such as knee arthroscopy, colonoscopy, and pregnancy and delivery, and that's included here in the outpatient because much of the care that's covered under the episode is outpatient, covers during the pregnancy and only the actual delivery is the inpatient piece. And you can see there's timeframes that are associated with each of these categories. We're able to use our data, the 2009 data, to look at potential savings for seven of these conditions. Those are the conditions that have the checkmark in the columns. And the reason that we could only look at these seven using our data right now was because that the data was limited to just 12 months -- we just had the period 2009 -- and so for all those chronic conditions, example, that require one year from the trigger date, we simply didn't have enough time series of data, because the diagnosis, frankly, didn't occur in the first month of 2009. But these seven give you an example of what the possibilities are, and for the chronic conditions, actually, we might expect even greater savings given their prevalence in the health care system.

So here are the seven that we're able to look at here. For the most part, the savings percentages range from about 10% up to about 44%, depending on the episode. So for example, for

coronary artery bypass, the potential savings are 44% of the total current expenditures for these episodes in 2009. This translates to about $35,000 per episode, or a total savings of nearly about $4 million across these 111 episodes. And while for the most part the savings are pretty substantial for each of these seven, you'll notice for colonoscopy the savings are less so. Since the savings are primarily about reducing the cost associated with the PACs, this means that this particular episode of care, the colonoscopy, doesn't often result in adverse events or services that are outside that typical care. And since the colonoscopies also occur quite often in our system, the per episode savings are relatively small. So the lesson there, I think, is that it just might be important to tailor, if you're going to tailor this kind of a thing, to certain conditions, you know, that do have the higher rates of PACs and that are more prevalent.

The total annual savings from just these seven conditions is estimated at about $26 million. We didn't extrapolate this up to so that it represents -- you know, this just represents savings for these seven conditions for the claims data that we had and were able to use, which came from three payer systems, so this is really less than half, actually. Even for these seven conditions it represents less than half of what we see in the

state. If we had all the claims from all the payers and we were also able to include all of the chronic conditions, the savings would likely be more substantial. So remember, the savings here really have to do with decreased payments related to those adverse events, or PACs. The proportion of spending on PACs for these seven conditions in Massachusetts that we found in the 2009 data varies by condition, and it varies when we compare it to US national averages that we were able to get. Here we're showing the percentage of patients for an episode of care for each one of those seven conditions that goes to pay for PACs on average. The bar shows the Mass percents for 2009. The orange box here represents the US average for that condition, and the green circle and the purple diamond show the low to high across the US, across all states. And as you can see here, the Massachusetts rate for the payment for PACs is lower than the US average for pregnancy and delivery and the bariatric surgery, and pretty close for the colonoscopy, so, you know, about -- I think for AMI, for example, about 23% of the total payment goes to pay for PACs on average. But Mass is higher than the US average for AMI, pneumonia, and gall bladder surgery, and particularly higher for [CABG?], where we're actually at the max spending for the PACs.

So as mentioned, the savings from the bundle payments in this particular model come primarily, though not exclusively, from reduced payments for PACs, which are the services and the costs that are not part of the typical care or the best practices. So what are these PACs? Well, the PACs for each of these conditions can be categorized into three different areas: services related to the initial condition, services that might be related to comorbid conditions, and services that might suggest patient safety issues or lapses. Each of those three categories can further be defined into where the PAC occurs or where the PAC money is spent, so the where and the how of where the service was delivered. Services delivered during the inpatient stay that were beyond the typical care, so during that initial stay, outpatient and professional services, and services that might have been delivered during a readmission that occurred after the initial stay.

Using our 2009 data we find that the percentage of PAC services is really pretty equally distributed among those related directly to the condition, those that are related to comorbid conditions, and those that might be related to patient safety lapses, so 38%, 29%, and 32% respectively. The least frequent are those that result in a readmission.

So what are these conditions? These here just represent the top ones that we found in our data that are related to that pneumonia example that we gave. Those related to the initial condition -- remember we're talking about pneumonia here -- are respiratory failure, intubation, lung collapse, and something I'm not going to attempt to pronounce. Those related to comorbidities were acute renal failure, urinary tract infections, meningitis, and stroke. And those suggesting patient safety failures include the sepsis, deep vein thrombosis, infections, and staphylococcus. So that gives you an idea of what we're talking about when we're talking about dollars that are related to the adverse complications.

So I hope that gave you some insight into the concepts of at least one payment methodology and one particular bundle payment methodology. You could actually learn more about some other models that I mentioned -- the Geisinger, the Minnesota baskets of care, some of the federal models -- on our website under a category under bundle payments. There's also information there from a forum that we did earlier this year specific to bundle payments. So now I think I turn it over to Susan Brown from the Attorney General's Office.

Susan Brown:

Good morning. My name is Susan Brown. I'm an Assistant Attorney General in Martha Coakley's Health Care Division at the Attorney General's Office, and I'm here today with Jen Smagula, who is an actuary at Gorman Actuarial. We'd like to give you a little bit of information about the review the Attorney General's Office did about global risk payments that exist in the Massachusetts market. I want to take this opportunity again to thank all of the payers and providers who submitted information for examination this year. Our report really would not have been possible without their cooperation and their help.

So what are global payments? Global payments are really just one way that insurance companies pay providers. The most common way right now in Massachusetts that insurers pay providers is through what we call fee for service. Fee for services payments or contracts, in those contracts insurers just pay each provider for each service or for each unit that those service providers give to their patients. On the other hand, in a global risk contract health care providers are put on a budget for all of the care they provide to their patients. So for example, if an insurance company and a provider negotiated a $400 per member per month budget, what would happen is throughout the year their providers would continue to submit claims to the insurance

company as though they are on a fee for service contract, but at the end of the year the insurance company would tally up all of those claims together, whether they're for hospital services, physician services, pharmacy services, you name it. They add them all together. If the average cost of care for all of the patients in the provider organization is more than that $400 per member per month then that organization is going to have a deficit. They're going to owe some money back to the insurance company. On the other hand, if the average cost of care was less than $400 per member per month, then they have what we call a surplus. They're going to get some money back from the insurance company. Because it's possible for providers to be in a deficit situation through these contracts, we sometimes say that they're at risk, or they're in a risk based contract.

Global risk payments are intended to save money in really one of two ways: first, by lowering utilization, by giving providers incentives to be more efficient rather than to have more volume of care; and second, by providing incentives for providers to refer their patients to low cost, high quality providers. To evaluate how global risk payments are impacting cost in Massachusetts, we reviewed total medical expense information, or TME. Total medical expenses are the total cost of care associated with a single patient, usually expressed per member

per month, so that total medical expense information reflects both the volume and the price of the services that are given to those patients. Now, we can adjust total medical expenses by health status so that we're accounting for differences in the sickness or in the age of different provider populations. Because total medical expenses accounts for volume and for price and can be health status adjusted, it is the best measurement of provider efficiency.

Global risk contracts are intended to lower cost by rewarding providers for efficiency instead of for volume. To review global contracts we tried to answer three basic questions: first, whether global risk contracts are related to lower health care spending; second, whether global risk contracts reward providers for being more efficient; and finally, whether providers in the market are ready to shift to global risk contracts. To answer our first question we reviewed total medical expense information. What this slide shows you is the total medical expenses for all of the providers in one major insurance company's network. Any of the providers who were paid on a global risk basis in 2009 are shown here in red. All of the other providers, who are shown in blue, were paid on a fee for service basis in 2009. What we'd expect to see if global risk providers are more efficient, is that they would have lower

total medical expenses, that those red bars would really cluster towards the left of the screen, but we don't see that. What we see instead is that those red bars are scattered throughout. We don't see a consistent relationship between total medical expenses and payment methodology. This is true even for those providers who've been in a global risk contract for more than five years, who we've indicated here with a yellow circle above the red bar. Those providers have more mature experience and global risk contracts, and the efficiencies that result from that experience should be reflected in their 2009 total medical expense information.

Here's the same data for another major insurance network in Massachusetts, and here, again, we see the same pattern. Global risk providers do not have consistently lower total medical expenses, even where they've been at risk for more than five years. This is the same information for a third major commercial health insurer in Massachusetts. The data just does not show that globally paid providers have lower total medical expenses than fee for service providers. One potential reason for this is that although global risk contracts are designed to reward providers for being more efficient rather than for volume, they don't always do that in practice. So how are they meant to reward providers for being more efficient? Going back to our

earlier example, the $400 risk budget per member per month, the idea is if that provider spends less on average on their patients than $400 per member per month, then that provider will be rewarded with a surplus, and so they have an incentive to be efficient. But that really begs the question, what is the budget?

Our examination found that risk budgets vary significantly from provider to provider in Massachusetts. For example, in one health insurance network in 2009 the global risk budget for one provider was about $425 -- I'm sorry, $430 -- per member per month, while the global risk budget for another provider was less than $300 per member per month, around $275. Now, these are health status adjusted budgets, so the provider wo has the higher budget, it's not higher because they're caring for sicker or older patients, they just negotiated a higher budget. Because these budgets vary so significantly, whether or not a provider receives a surplus is more a function of how high their budget is set, rather than how efficient they are. So let's look at this graph for just a quick example. Ignore the blue lines for a moment and just focus on the red bars, just looking at the global risk providers in this particular insurance company network. If providers are rewarded for being more efficient, what you would expect is that those providers who have the lower

total medical expenses would be receiving a surplus, so those red bars that are on the left of the screen would be rewarded by the insurance company for being more efficient with a surplus at the end of the year, but what we see is that this isn't always the case. In actuality, sometimes providers who have lower total medical expenses owe a deficit to the insurance company at the end of the year. On the other hand, some providers on the right hand side of the screen who have higher medical expenses might receive a surplus at the end of the year. This is consistent with the Attorney General's findings that payments from insurers to providers are not value based and do not consistently reward efficiency, regardless of whether those payments are made on a fee for service or a global risk basis.

As part of our examination of global payments, we also examined the alternative quality contract, or AQC contract, recently introduced by Blue Cross Blue Shield into the market. The AQC is a global risk model that is designed to constrain cost trends by reducing the increase in cost trend for each provider over a five year period of time. We reviewed AQC information to see if 2009 AQC contracts, as negotiated, are likely to result in cost savings as compared to non-AQC providers. What we saw was two things: first of all, that between 2008 and 2009 AQC providers experienced an increase in both their relative price and in

their total medical expenses. Next, we were able to use contractually set medical trend adjusters to project the total medical expenses of those providers all the way to the end of their five year contract to 2013. That’s what you see here on the purple line. For illustrative purposes, we then trended for the non-AQC total medical expenses to 2013 to understand what the difference is between AQC and non-AQC total medical expenses. When we did that what we see is that it is unlikely that by 2013 total medical expenses will be lower for AQC providers than for non-AQC providers. This is particularly unlikely, not to mention undesirable, because it’s unlikely that non-AQC providers will experience a 9.75% or greater increase in trend.

Our examination also shows that there are challenges associated with global risk contracts that providers in the Commonwealth might not be prepared to handle. First, providers have to make significant financial investments in order to bear risk. They need financial expertise to understand claims trend and to engage in risk negotiations. They need to build financial resources to manage potential deficits, such as risk-based capital or lines of credit, and they need to purchase insurance. One provider with experience in global risk contracting in Massachusetts testified that their ability to successfully

operate within a risk environment is a result of multiple millions of dollars in investments. It’s also important to note that providers in Massachusetts even still have limited experience in global risk contracts. Today, less than a quarter of commercial members and the largest three commercial insurance carriers currently have their care reimbursed through global risk contracts. Finally, global risk budgets expose providers to insurance risk that they might not be prepared to handle. Health insurance companies are in a better position to manage risk because they can spread that risk across greater, larger risk pools. They have re-insurance, and they have other sophisticated tools for managing that risk. Now I’d like to introduce Jennifer Smagula of Gorman Actuarial. Ms. Smagula is going to review some of the important data that we examined in our analysis this year around global risk agreements.

Jennifer Smagula

My name is Jennifer Smagula. I’m a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. Since July 2010 I have been an actuarial subcontractor of Gorman Actuarial where I have focused on assisting state governments and analyzing the impact of health care reform policies on the

insured market. Prior to 2010 I was responsible for pricing and trend analysis at two health insurance companies in Massachusetts, Blue Cross Blue Shield of Massachusetts and Harvard Pilgrim Health Care. I am pleased to testify today about my work on the AGO examination of health care cost trends and cost drivers. I will focus my remarks today on the measures the AGO used to analyze the performance and experience of globally paid at risk providers in Massachusetts.

As you heard from Bella Gorman on Monday and again from me yesterday, the AGO obtained detailed information from the major health insurance carriers on total medical expenses, or TME, which is the medical cost or spend per patient. The TME produced to the AGO by the health plans was health status adjusted to account for the demographics and health risks or morbidity of the populations cared for by each provider system. This enabled comparison of relative spending per patient and ensures that systems caring for populations with higher morbidity will not inaccurately appear as higher spending systems. Since TME is health status adjusted it is a good measure of efficiency. A lower TME will reflect lower utilization, lower prices, and/or lower mix of services. We compared the payment methodology of providers to their health status adjusted TME to determine whether providers that are compensated under a global risk

structure have consistently lower TME than providers who are paid under a fee for service structure. We found that providers compensated by Blue Cross Blue Shield, Tufts Health Plan, or Harvard Pilgrim Health Care under a global restructure did not have consistently lower TME than providers who were paid under a fee for service structure during 2009, the most recent year for which information was available at the time of our review. We were also able to review information from Blue Cross Blue Shield regarding providers who participated in the alternative quality contract in 2009, including preset medical budget trends for each AQC provider for every year through 2013. By analyzing this information we were able to project the future TME for those AQC providers in a way that cannot be done for other at risk providers. We compared AQC and non AQC TME and trends on a risk adjusted basis. Given the risk adjusted 2009 TME of both AQC and non AQC providers and the AQC negotiated medical trend factors, it is reasonable to conclude that 2009 AQC providers will not have a lower TME than non AQC providers by 2013.

The AGO also examined the global budgets negotiated between health insurers and providers. In response to the AGO's civil investigative demands, health plans provided the annual settlement statements and risk contracts for providers they pay on a global basis. This information enabled us to compare the

size of the global budgets that health plans negotiate with different providers. The plans also provided us with health status scores that measure the demographics and morbidity of the populations cared for through global budgets. This way, in comparing the size of the global budgets, we were able to adjust for differences in demographics and morbidity, so we were comparing budgets negotiated for similar populations. We identified wide variation and the global budgets negotiated from provider to provider that is not explained by the higher paid providers caring for populations with higher morbidity. The data I reviewed, examined from multiple perspectives, supports the AGO's findings that providers who have global risk contracts do not consistently have lower TME on a health status adjusted basis compared to providers who have fee for service contracts, and that there is variation in global risk budgets that is not explained by differences in morbidity of those providers' patient populations. The AGO's analysis of global payments is valid and reasonably relies on the information produced by insurers. Thank you.

Susan Brown

Both the Attorney General's report and the work of the Division highlight the dysfunction that is prevalent in the Massachusetts health care market. Market dysfunction affects how we negotiate and pay for providers for the delivery of health care services, regardless of whether those providers are paid on a fee for service or a global risk basis. It is critical that as a Commonwealth we begin to address this dysfunction by promoting value based purchasing. Tiered, unlimited network products encourage value based purchasing by rewarding consumers who choose more efficient providers, and by shifting volume to high quality, low cost providers. In addition, where providers do choose to enter into global risk contracts, we must develop appropriate regulations and solvency standards so that providers can safely and adequately manage that risk. Thank you very much, look forward to your questions.

Seena Perumal Carrington

Thank you, Stacey. Thank you, Susan. For the sake of time, actually, we'll move to Harold Miller's expert testimony and

then save the Q&A for the Attorney General's Office, the Division, and Harold at the end. Thank you.

Harold Miller

Thank you, and hello, everybody. It's nice to be here. I'm going to apologize in advance to the ladies in black because I talk fast and I'm expecting you're going to get severe muscle cramps by the time (laughter) I finished. So be prepared to rescue her if she... So I'm going to try to explain some of the elements of all these different payment concepts, how they work together, what do you need to do to make them work, and do that all in 30 minutes, so wish me luck. (laughter)

But I'm going to actually start with the notion of the accountable care organization, which everybody in health care these days is talking about as the way to try to save costs, and then how do you pay accountable care organizations to do that. And I've been troubled by most of the discussions about this when you go to ACO conferences or if you read the ACO regulations from the Center for Medicare and Medicaid Services is that everything is focusing on how much risk providers can take and who should be on the Board of the ACO, and nobody's

talking very much about what exactly is actually going to happen inside this ACO that's going to save money. And I think fortunately for most of us, the general public hasn't heard anything about this yet, because I think that when they do what they're going to think is happening inside this black box could well be rationing, and that I think there is a real fear that if we're not careful about how we go about this that some people may declare themselves to be ACOs and figure out that the way to save money is to deny care to patients. I think that what we should be focusing on first, before we talk about payment, before we talk about anything else, is what exactly is it that we think we're going to do to be able to reduce cost without rationing, and then how do we support that happening.

Now, a lot of people seem to think that you can't actually reduce cost without rationing, that you're going to have to take away things that patients want or need to be able to reduce costs, and I don't buy that. I think that there are three major ways that you can reduce cost without rationing. One is by keeping people well. If they're not sick, they don't have health care costs at all. If they do get some kind of a health condition, a chronic disease, to be able to help them manage that condition in a way that reduces the frequency with which they have to be hospitalized or have acute care episodes. And if

they do end up with an acute care episode or a hospitalization, that they survive the experience -- that they don’t get infections, they don’t get complications, they don’t have to be readmitted, and that that acute care gets delivered in the most effective, efficient fashion possible.

Now, the good thing is all of these approaches will actually save money, and they are also better for the patient, and I think that if we were to tell the citizens of the Commonwealth of Massachusetts and the folks in the United States that what we’re trying to do with all of this ACO payment reform stuff is to help them stay well, help them avoid having to go to the hospital if they don’t need to, and make sure that they have a good outcome when they do, that people would say, “Sounds pretty good to me.” Now, once you decide that this is what you’re trying to accomplish, that’s when you immediately run into the problems with the current payment system, because the current payment system goes in exactly the opposite direction. Doctors and hospitals make more money when patients get infections and complications. Doctors and hospitals make more money the more frequently people are sent to the hospital, and nobody in health care makes any money at all when patients stay well, so what kind of incentive is that to be able to achieve what we’re trying to accomplish?

So the question then becomes, how do you fix that? How is there a better way to pay for health care that will enable you to achieve these kinds of reductions in cost without rationing. So the first big idea is the notion of episode payments, which Stacey talked about earlier, but it's basically -- at its core, the idea is a single price, single payment for everything that you need or have to get during a particular episode of care, and critical to this is the notion of a warranty for complications. That's the potentially avoidable complications concept that Stacey was talking about. This is what every other industry in America does is give warranties on their products and services, that you don't pay more if there is a problem that the person delivering that product or service creates, but we don't do that in health care. Now, this sounded like an insane idea up until a few years ago when the Geisinger system in Pennsylvania started to do this. They didn't call it a warranty, the *New York Times* called it a warranty, but the idea is single payment for everything that happens to you, both hospital and physician payments, post-acute care, and importantly for addressing any kind of related complications or readmissions, and they started this with cardiac bypass surgery and have been systematically expanding this to other kinds of conditions, including things like maternity care and back pain. And what they found is this

is actually a win-win-win: that the patient is better off -- not little itsy bitsy improvements but 20-40% reductions in complications and readmissions; the hospital is better off financially, actually makes more money; and the health plan is also better off, they save money. So wow, that's the kind of outcome you want: the patients are better off, the hospital stays solvent, and the payer is spending less money. That's the opportunity through the warranty approach.

Now, the myth that has developed about this is that you have to be a Geisinger Health System to do this. You have to be a big, integrated system to be able to do something like offer warranties. Well, the earliest documented example of this is a single doctor in Lansing, Michigan, orthopedic surgeon, who said 25 years ago, "I'm going to give a two year warranty on my shoulder and knee operations. Anything goes wrong I'll fix it, no extra charge." And it's documented in the literature, doctor made more money, hospital made more money, payer paid less, patients were better off, because it gave them the opportunity to complete reinvent the way they were delivering care, to eliminate all the unnecessary services that were there because they got paid more for them, and to be able to actually improve the quality of care.

Now, the problem with the episode payment model is it does potentially a lot to try to help improve what happens inside episodes, but what does it do to prevent unnecessary episodes of care? If you're managing your chronic disease patient population, the idea is not that every time they go to the hospital they have an efficient, successful outcome. You want them to go to the hospital less often, and you want to reduce the unnecessary cardiac surgeries and back surgeries that are going on in many places today.

So the second big idea in health care is what I prefer to call comprehensive care payments, what a lot of other people call global payments. I don't particularly like the term "global payment" because I think the patients are going to think we're sending them to India or Thailand to get their care. The idea is single payment for comprehensive care of your condition, everything you need, regardless of how many times you have to go to the hospital or get procedures done. Now, the immediate reaction a lot of people have is that global payment, comprehensive care payment is capitation, and it's important to recognize it is not. The idea is to do something that is better than traditional capitation systems. Under traditional capitation systems, a provider who had capitation got no extra money if they took on sicker patients, so the idea is to fix

that so that you actually get paid more if you have sicker patients, you're rewarded for taking on and managing sicker patient population. Traditional versions of capitation, provider lost money if they got the unusually expensive case. The million dollar cancer comes along, you don't get any more money for that, it could send particularly a small provider into bankruptcy, so the idea is to have limits on the total amount of risk that providers can take, particularly for these unpredictable events.

Third problem with traditional capitation was that there was no distinction based on the kind of quality of care that was delivered. You got paid no matter what. The old line about capitation was the way to succeed in capitation is to do as little as possible for as many patients as possible. So we want to fix that. We want to have some kind of recognition and reward or bonus or penalty based on your quality. But two very good things about capitation, which is why people are interested in the global payment notion, is it's the only payment system that actually rewards a provider for keeping their patients well, because they continue to get paid if their patients stay well. That's a good thing and that we want to keep. And second is that it's the most flexible payment system. You are no longer as a doctor or hospital constrained by what Medicare or a health

plan says they will pay for or won't pay for or how much they'll pay for it. You have the flexibility to decide and deliver what your patients need. So the idea of a well designed global payment or comprehensive care payment model is that it takes the best aspects of traditional capitation systems, fixes the worst, and creates a better payment model, and this is what I think Blue Cross has been trying to do here in Massachusetts through the alternative quality contract. Single payment for all the costs of care for a population of patient, but risk adjusted with a quality bonus that recognizes better quality care. But an important feature, I think, of their model is that it's a five year contract, and that allows a provider to be able to reap the investments that they make in things like prevention and things like health IT, and have gotten broad participation, and I think that the results that they have reported are very positive in terms of both higher quality and tackling some of those things like readmission rates and ER utilization that could save money.

These are not either/or concepts. An important thing to understand is somebody could get a global payment and then turn around and pay a hospital, for example, an episode payment, because if you're managing that chronic disease population you want to be able to give them good quality care and sort of keep them out of the hospital, but when they go to the hospital you

want the folks in the hospital to be making sure that they don't get infections and complications and that they get the best quality care there.

So let me take a little deeper dive into these concepts and talk about what some of the key elements are. Now, a challenge is that there is no sort of stone tablet anywhere that tells you exactly what an episode payment is. There are many ways to define it, and there are really three different concepts in it. And I'm going to disagree with Stacey a bit -- I'm not going to say that bundling and episodes are the same thing. Bundling is the notion of trying to take two different providers that get paid separately today and pull them together and pay them jointly: doctor and hospital, hospital and post acute care. Separate concept is the notion of a warranty, which is that you're not charging or being paid more for treating infections, complications, things that you could've prevented. You can have bundling without a warranty. You can have warranty without a bundling. So the two depends on what you're trying to accomplish. And the third concept is a condition specific payment, so paying based on a patient's condition, not a particular treatment. One of the great myths of health care today is that we have what is called the diagnosis related group system that Medicare invented back 25 years ago. It's not

really a diagnosis related group system; it is a treatment related group system in most cases. It pays based on the treatment that you get, and that's an important factor, too.

Now, I don't have time today to go through all of these concepts, but I'm going to focus on the notion of the warranty, which I think is one of the most critical elements of all of this, and ask the question, so can this be a win-win-win? Now, the first sort of mind-bender that you have to deal with with the notion of the warranty is that the price for warranty care will likely be higher than it is today. This is really a challenge for people to think, "Well, we're trying to save money for health care. Why would we be paying more to get good quality care?" But if you think about it, in every other industry if you buy a product with a warranty you would expect to pay more for that product with a warranty than a product that doesn't have a warranty, because you know that you would no longer have to pay for the cost of repairs, et cetera. The question becomes how much more do you pay, but in health care it's the same concept. So a DRG payment to a hospital with a warranty would need to have a higher payment price than an equivalent non-warrantied DRG, because the higher payment is going to be offset by the fact that you're no longer paying for all the complications, outlier payments, readmissions, et cetera.

Let me give you an example. Take a hypothetical $10,000 procedure, something that health plans are paying $10,000 for today, but 5% of the time the patients who get that procedure get an infection, and it costs -- every time the patient gets an infection it costs $20,000 to treat that infection. So what's the payer actually paying for these patients? It's actually paying, on average, $11,000, because when this procedure goes well they pay $10,000, but 5% of the time they pay $20,000 more, so on average they're paying $11,000. Now, if you were the provider and you were going to offer this same procedure with a warranty, you were no longer going to charge for infections, how much would you charge for the procedure with a warranty? Well, the answer is you'd charge $11,000, because if you charged $11,000 you end up now getting exactly the same amount of money that you got before. So why do it? Well, the answer is all the incentives have now changed, because now if that provider can reduce the infection rate to 4% its costs will go down, because it no longer has to treat as many infections, but its payment stays the same so it actually makes more money by delivering better quality. But we want to save a little bit of money in health care, so that provider could actually now offer that same procedure at a lower price. They could say, "We'll offer that procedure for $10,800," and hopefully a health plan will be able

to send them more patients because they're now offering better quality care at a lower price, and the incentives continue because now if that provider continues to find ways to drive down their infection rates they will reduce their costs and make more money so their incentives are aligned. And in the end you end up with driving as close to zero as possible on the infection rate, better quality for the patients, you are spending less money, the cost is lower for the payers, but the provider is more profitable. Win-win-win.

Now, this is in contrast to sort of a typical Medicare and many health plan approach, which is to say, "Let's just not pay you." I wore her out, OK. (laughter) "Let's not pay you for infections. " Well, the problem with that is that long before the provider figures out how to get rid of all those infections you made them lose money, because they're still having to treat those infections but you're not paying them anything for it, so you immediately put them into a loss situation, and all the way along that they're trying to figure out how to reduce infections they're losing money, as opposed to having them be able to financially benefit.

So that's the notion of acute care and episodes, but, as I said earlier, we don't just want better acute care, we want to get

less of it. And the truth is we know in health care ways to get not little itsy bitsy changes in terms of reducing hospitalizations but big 20, 40, 60% reductions in the rate of hospitalizations for people with chronic disease by doing very simple things: by doing patient education, self-management, support, telemonitoring. The challenge is we don't pay for those things in health care today. This is my picture of how we pay for health care today. We pay for physicians to do office visits with patients. We don't pay for phone calls. If you ever wonder why you can't get your doctor on the phone, because they don't get paid to talk to you on the phone. They only get paid to see patients in the office. We don't pay them to hire a nurse to work with chronic disease patients, to be able to keep them out of the hospital, but every time their patients show up at the ER, every time they show up at the hospital, every time they get a test we pay for it. So the notion of global payment basically says, "Let's give the provider the flexibility to figure out what's the best kind of care for the patient, and if answering the phone, if hiring a nurse will actually be better for the patient, then we can invest in that. We have the flexibility to invest in that because we will be able to reap the return in terms of reduced ER visits, hospitalizations, et cetera."

Now the challenge, though, is that that's a big leap. So if you're a physician practice and you're getting paid fee for service today, to all of a sudden say now you're getting global payment and you're at risk for all hospital costs, big jump. So people have been looking for transitional models: how do you actually get there without giving all this risk? So what the federal government is trying to do is the notion of shared savings. The shared savings model says to a, say, primary care practice, if you somehow can figure out how to reduce hospitalizations and ER visits, et cetera, and save us some money, we'll give you a piece of that back in a year or two. So of course, natural approach for primary care practices go to their very big bank accounts, their large reserves that they have, draw down on that, make investments in better care, save money, and get some of it back in a couple years. Doesn't work for most physician practices, and I'm not a big fan of shared savings for a lot of reasons. The first one is it doesn't give any upfront money to physician practices to be able to do better. Second, it still puts them at risk for total cost, because the only way they get shared savings is if total costs go down. They could be doing a lot better job to manage those chronic disease patients, but they end up with other cost increases. They don't win.

I think the folks in Miami will probably be a lot happier with shared savings because the folks who have high rates of utilizations can save a whole lot more, but the fundamental thing is it doesn't -- it's not payment reform -- doesn't actually change the underling fee for service system. It's just a new kind of pay for performance bolted on to the top of the existing payment system. What's a better solution, a better transitional approach that physician practices could manage? We want to simulate the flexibility and incentives of global payment without necessarily jumping to a full global payment system right away. So what would you do? Well, you could give the primary care practice some upfront money, as many medical home programs are doing, money that they could use for phone calls and nurse care managers, but you also want them to take some accountability for making sure that that additional money is actually saving some money somewhere else. So to say, "Let's have some targets for reducing utilization in the ER, hospital, et cetera," and tie that to a pay for performance kind of bonus or penalty, which then comes back to the physician practice, so they're now getting the right kind -- they have flexibility, they have more money upfront, but they have incentives to be able to focus that on reducing total cost.

This is what the state of Washington just began this month to put in place as their medical home pilot. They are giving primary care practices small amount of flexible money upfront, but the practices are agreeing to targets in terms of reducing preventable ER visits and ambulatory care sensitive hospitalizations. If they beat those targets they get a bonus, they get a share of the savings. If they don't beat the targets they have to pay some of the upfront money back, so they have some upside and some downside risk, but it's manageable for them, and it's focused on things that they can control.

So I want to talk about my list of six things, six additional things that you need to put in place to make payment reform work, and the first, I think, is transitional payment reforms, that not everybody is going to be prepared to leap all the way to a global payment system or to a full episode based payment system right away. You need to be able to have medical homes, what I call accountable medical homes, like the Washington State example, the episode payment model for particular conditions, where physicians can take that on, a condition specific capitation notion where you're paying for a particular condition, for managing that condition, not everything, et cetera.

Second thing that I think you need to have in place to be able to make payment reform work is to be thinking about how to support prevention and long-term returns on investment, because all these things I've been talking about -- episode payments and even those medical home programs -- are focused on one year outcomes. They're one year contracts, and so what you get and what you have to save has to occur within the course of one year. So the problem is that most prevention programs don't save money within one year. They save money over a much longer period of time. Global payment could help, but only if it's based on a multiyear contract, and that's, I think the significance of what Blue Cross has been trying to do is to say, "Let's think on a longer term basis than just one year at a time to be able to make that work."

Third element that you need to have in terms of payment reform is make sure that you're making providers accountable for what they can control, not what they can't control. So for example, if you said, "So how much should I price this episode or global payment at?", a typical approach is to look at what the costs have been over the past several years in fee for service and say, "Let's put the initial payment at that level or just about," and then say, "We want to try to control the increases in costs over time." The notion is that if the provider, under

this new payment model, can then keep their costs within that level, the payer's saving money because they're not experiencing the continuing increases that they would've otherwise, and the provider saves money, which, problem is, what happens if the costs continue to go up? Then the provider ends up losing money. Well, that's the deal, right? Sort of, you know, upside and downside risk. The problem is that there's a bunch of different reasons why total costs can go up. Some of it is sicker patients, and you can adjust for that. Some of it is those unusually sick patients. You can adjust for that. But some of it is the patients decide to go out of the region for care. They go to Florida in the winter and run into a lot of hungry dermatologists and cardiologists who decide to load them up on treatment. Their patients can only go to one particular doctor or hospital that delivers that care, and that's a monopoly, and it charges high prices. It may be because they have higher utilization; that's something that the provider can control. It may be because the provider's inefficient. So some of those things the provider can control, some of them they can't. So the provider performance risk has to be distinguished from the insurance risk, the things that the provider can't control, and that has to be built into the contract. And the problem with trying to right now just look at total medical expenses and compare them is that we're not sorting out all of those

different reasons why one provider may be more expensive than another.

The fourth is to be able to sort all that out you have to be able to access data, and this is one of the biggest limitations I have seen for most providers today is that they don't have the data to be able to understand how often their patients are being hospitalized, how often they're going out of network, et cetera, and so you need -- the provider needs to have that data if they're going to figure out, so how do I price my warranty? How do I know that that's going to work for me? The payer needs to have that same kind of analysis to tell whether the provider's warranty price is a good deal for them or not. Is it more or less than I would've been paying otherwise? And both sets of data have to agree, because the last thing we want to do is to spend years with the providers and the payers sitting and arguing over different data sets. We want to be able to get to moving towards payment reform. And it has to be some kind of multi-payer structure, because if every payer is giving the provider different data in a different format, the provider's going to end up spending more time trying to figure out how to reconcile the different data formats, so having some kind of multi-payer data set, the way the State has created, and also

having good mechanisms for being able to have the providers understand how to use that data are going to be very important.

Fifth is we need to have better methods of controlling prices. Now, “Wait,” you say, “I thought that’s what payment reform was supposed to do.” Well, I hate to break it to you: payment reform alone will not control prices. Payment reform is about changing the method of payment, and to be able to remove the incentives we have today for higher volume and the barriers to reducing costs. But no matter what the payment method is, prices may end up being too high or too low. If the price is too high, you get no savings. If the price is too low the providers end up going bankrupt. So you have to figure out how in addition to changing the incentives you’re going to get the right prices. So we do a little bit more detail breakdown.

So within element five there are multiple elements for controlling prices. First of all, you have to have prices that people can actually understand and compare, and so the long hospital charge master or the 7,000 CPT codes is not exactly a prescription for patients being able to figure out how to compare prices. So today, for example, I’ll take my example of the $10,000 procedure. You see two providers; one has $10,000, one offers the same procedure for $9,500. Is provider two the

better deal? 5% less. But what if it turns out that provider number one has a 5% infection rate and provider number two has a 10% infection rate? Well, it will turn out that on average provider number one is actually being paid less than provider number two, even though it looks like it's charging more for the basic procedure. So without knowing the data in terms of what's their infection rate, what's their complication rate, what are the other things that go along with that, you really can't compare prices. So in fact, if somebody comes along with a warranty, that provider number three that says "I'm not going to charge you for infections" might be charging more than either of them for the basic procedure, but still you would be spending less than the other two.

So one of the things what payment reform can actually do is to simplify the comparisons, so if I'm comparing episodes rather than procedures and infection rates and everything else, I have a better ability to determine who is more expensive and who is less expensive, and the same thing if everybody is being paid on a global payment basis I can tell who is more expensive and who is less expensive.

Now, we've got to sort out some of these other things like medical education, so you can't compare a teaching hospital and

a non-teaching hospital if one is trying to charge more to cover its teaching expenses. You can't compare a hospital that's got special services for low income populations that others don't. You have to be able to find different ways of sorting that out. Second thing that you need to be able to control prices is that you have to have providers able to change their prices for individual services. In fact, most providers can't do that today because the contracts that they have with health plans basically give them one uniform set of weights and then they adjust simply what's called the conversion factor. So they have to be able to say, "If I think I can charge less for this," that they can do that. Then, only then, after you actually get some greater comparability can you go towards transparency, and simply reporting charges but then having secret discounts doesn't work. And you talked earlier about the variation in prices. The variation in prices is not just a Massachusetts problem. MedPAC, Medicare Payment Advisory Commission, just came out with a report a couple weeks ago that showed -- that's Boston second from the left -- but other people have, around the country have the exact same problem. You've got to get that information out in order to be able to compare it. So you need publicly reported prices, which all payers pay, not with secret discounts behind the scenes.

The fourth is that you've got to get the consumers into this game. Now, the problem in health care is that we think we're doing this through copays, coinsurance, and high deductibles. We think that's the way to give consumers skin in the game, and the truth is it doesn't work very well. What it actually does is discourage people in many cases from getting the care that they need. Now, it's a little hard to understand sort of how to make it work in health care, because people think, well, health care is the only circumstance in which somebody else pays for the service. The consumer is picking but somebody else is paying for them, right, so they're disconnected from care. But this actually happens in, yet, one other area, which is travel reimbursement.

So let me take you out of health care for just a second. I have to be in Cleveland tomorrow. What are my choices to get to Cleveland? I could take a United nonstop first class flight and pay $1,355. I could take nonstop coach and go for $1,100, or I could take US Airways, fly through Philadelphia, and go for $622. Now, if somebody is reimbursing me for my travel, which one will I pick? (laughter) Now, if we were doing travel reimbursement the way we do it in health care we would say, how would we make the consumer, what would be the consumer's incentive? You'd say, "Well, OK, Harold, I'll make you pay $100

copayment." Which trip will I take? I'm going first class. 10% coinsurance. Now, who here would not spend $74 more to avoid having to go through Philadelphia and to be able to sit in first class? I have a $500 high deductible travel reimbursement policy. Which trip do I pick? But we don't do that in travel reimbursement. We say, "We'll pay for the lowest coach fare. That's what I'll reimburse you for. Harold, if you want to go first class you can pay the $733 difference. Up to you." So if you're in Massachusetts and you want to get your knee replaced, what's your choice? Well, if you look at the Division's report, minimum $5,200, maximum $50,000. Under my $1,000 copayment program which one will I pick? Even if I have 10% coinsurance, if I have a $2,000 out of pocket maximum which one will I pick? Well, you look at that and you say, "Wow, for $1,500 more I could get the $50,000 knee replacement. I bet it's better." $5,000 high deductible plan? I'm going for the more expensive knee. It's only if I say to you, "You can get your knee done for $5,000, and if you think the one that's doing it for $50,000 is better, you pay the difference." So we've got to have consumers thinking about what that last dollar of charge is, not having them pay so much on the first dollar, and then they have to have a choice of providers. Doesn't matter what their skin in the game is if they have no choice. I'm actually -- I live in Pittsburgh and I'm going to back to Pittsburgh tonight and then

driving to Cleveland, but if I were to look at this from Boston I could get to Pittsburgh for $188. It costs me $1,100 to go nonstop to Cleveland? Why is that? Is that because Cleveland is farther away? No, it’s because there’s actually choice, because there are three different airlines that will fly nonstop to Pittsburgh and only one that goes to Cleveland, so guess why it costs ten times as much to go?

So you’ve got to have a choice of providers offering these different services. And what would happen if consumers actually had choice and considered price? Well, they did this in Minnesota back in the 1990s, had providers bid on the cost of services, and then the consumers had complete choice about where they went, but if they decided to go to a more expensive system on a globally priced basis, they simply paid more. What happened? A lot of consumers decided to switch and the providers then decided to lower their prices to be able to retain those consumers.

So the final thing, then, is you have to have good information on value, so the consumers have to understand whether this is low cost and low quality or low cost and high quality. So this is a concern that people have about global payment models is, is that going to cause providers to reduce quality, to stint on

care? So the solution to that is that we have to be able to actually measure quality and report on it so people know about that. We are a lot farther ahead than we were back in the old days of capitation today. The question, though, is where do you do this? Is this going to be done at the national level through Medicare reporting? I think people will be a whole lot happier if you end up doing it at the community level, and a lot of communities are doing that, and you have the capacity to do that here in Massachusetts through Massachusetts Health Quality Partners to be able to actually report this data with the involvement of the providers themselves. So community based information on both cost and quality.

So all of that is how you get better control of prices, and then the final thing is patient support. So that's the benefit design side of the equation. Payment affects how the provider changes the way they -- are they more efficient, et cetera -- but the patient -- it takes two to tango in health care, so you've got to get a patient in the game. And I understand a lot of discussion about that yesterday on the benefit design side, but the patients have to have the right ability and incentives to stay well, to help have somebody coordinate their care, et cetera. I think one of the biggest and most critical aspects of this is pharmacy benefits, because we have a complete disconnect

in this country today between pharmacy benefits and medical benefits, and if you're trying to manage those chronic disease patients and help them stay out of the hospital, and the major thing that keeps them well is to take their chronic disease maintenance medications, and they can't afford them because the copays are too high or they're in the Medicare donut hole, what's the doctor supposed to do? But it's also thinking about the right way to be able to encourage people to use an accountable care organization. Everybody's jumping immediately to the idea that we either have to lock the patient in or we have to charge them more if they go outside the ACO. I think actually payment reform is the right solution to this because if a provider can actually have the flexibility to reinvent the way they deliver care and offer a better quality service to patients, I think patients will want to stay with that provider, and we don't need to penalize them or lock them in.

So in conclusion -- you'll be able to rest soon (laughter) -- no one size fits all solution to any of this. I think it has to be Massachusetts' needs and Massachusetts' solution, and the best federal policy is going to be one that supports regional innovation. Payment reform is necessary but not sufficient. You will not solve all these problems just by doing payment reform. You can't do it without it, but you need to figure out how

you’re changing delivery system, how you’re changing benefit structures, how you get better quality reporting, how you get better consumer education and engagement. And critical -- I think all the stakeholders have to work together on this, because there’s going to be a lot of bumps in the road, and people have to be able to sit down together on a multi-stakeholder basis and work through this, because the community should say, “This is what we need to be able to accomplish.”

So that was my 78 RPM tour of payment reform and other associated things. Lots more stuff on our website, and I would be happy to answer questions.

Seena Perumal Carrington

Thank you, Harold.(applause) So I received several questions from audience members, and Harold, feel free to chime in at any point. There’s -- some are specific to you, but other are for both Stacey and Susan.

Harold Miller

All right.

Seena Perumal Carrington

So I'll start with the technical questions first. Stacey, does the Prometheus model neutralize for price differences?

Stacey Eccleston

Well, assuming that by price differences you're, we're talking about the prices that different providers pay, or even within a provider, it really depends on the data that you use to apply the model to, so in a sense it does. Certainly the data that we use was multi-provider data, so that dollar amount, the $9,000, I think it was, for the pneumonia that was the case rate there, was based on an average across all of providers. If you only applied the model to one payer data set and limited that to just one provider, then no, you would be getting dollars that were based on that particular provider's dollars amounts. I don't know if you had anything else... Do you have a...? No.

Seena Perumal Carrington

Two questions for you, Susan. In looking at budgets, did you account for differences in unit prices for care provided in various provider groups?

Susan Brown

So because we were looking at risk budgets, although risk budgets are related in negotiations to where the individual prices for units of service are set, the budget itself really is the price. That is the amount of money that the provider will be paid. It is important to look at unit prices, however, because obviously in Massachusetts providers who are at risk are only at risk for their HMO patients. On their PPO patients, they're still being paid on a fee for service basis. So if you want to get a good sense of how providers are being paid overall, you have to look both at their aggregate price, the aggregate price that's being paid to that provider, and again, you have to look at their total medical expenses, which reflect not only the budgeted, negotiated amount, but also the fee for service prices

that are being paid on services that are carved out of those global budgets, so things like behavioral health or high pharmacy cost items that aren't included in those global budgets. So it is important to look at both. And when we were comparing the risk budgets for the purposes of our analysis, we were looking at just the negotiated global risk health status adjusted budget.

Seena Perumal Carrington

Another one for you, Susan: Is it reasonable to conclude that global payments do not save money when TME calculations do not include PPO information, which accounts for nearly half of payments?

Susan Brown

That's a great question. (laughter) It's reasonable to conclude that they don't save money on total medical expenses where global payments are implemented, which is only on the HMO side, and so that's what we evaluated. There are global payments on the PPO side. Right now there are no providers in Massachusetts who are being paid on a risk basis for their PPO patients,

because of the reasons we really discussed yesterday: that if you don't have a primary care provider, if you don't have access to the critically important information we just heard about from Harold Miller, it's very hard to coordinate the care of your patients and stay within a risk budget. Therefore, when you're looking to see whether or not risk budgets -- or really, I mean, this is a broader conversation -- when you're looking to see whether any intervention at all is saving money, the way you have to look at it is by examining the total medical expenses associated with that population, and here we could do that for the HMO patients who are at risk.

Harold Miller

So since you invited me to chime in (laughter) I'm going to take the opportunity and say I think, first of all, one has to be careful about the, if you'll pardon the term, global conclusion from a narrow analysis, which is to say we looked at a couple examples of how global payment was implemented here, and what it did does not tell us whether the payment model itself is, does something or doesn't something. It tells us how it was implemented. And what isn't clear to me is that you have sorted out all of the things that are the drivers of costs. My

understanding, for example, of the Blue Cross contract, as I mentioned on an earlier slide -- which I will see if I can figure out where that was -- is that they exclude some of these cost drivers from the risk for the provider -- so in other words, the provider is not responsible for some of those things. So to be able to fairly evaluate the model you would have to say, “Let’s figure out whether the providers controlled the stuff that they were actually responsible for controlling,” because they were not responsible for total medical expense. They were responsible for a subset of total medical expense, and so you have to ask whether they controlled the piece that they were responsible for. Second is my understanding is Blue Cross paid a quality bonus. Now, in the short run that ends up actually costing more money, but the idea is -- it goes back to the thing I raised earlier, which is that you may have to invest in the short run to be able to achieve longer run savings, including beyond the five year contract. So simply comparing what the result of that is over the five year contract may not be a fair comparison given what they did. The other thing is it’s my understanding that there were some different patient populations that some of those providers took on between 2008 and 2009 which could’ve changed the populations, and I think that has to also be factored in. So I would be very cautious about drawing a broad conclusion that says we looked at one

particular implementation of global payment, we -- and tried to use a gross measure to say whether the payment model works. I don't think it's a measure whether the payment model works, I think it's a question about whether or not that particular implementation was successful.

Susan Brown

Sure, and I just want to be clear, following up to that, that the question really critically here is what are you evaluating for, what are you solving for? And here, our analysis, what we were trying to answer, was does it save cost to the system as a whole? So the question, when you're saying, "Does the payment method work?", the question is "What do you mean by work?" And what we were looking at only was whether or not it works in the sense that it saves cost to the total system. And to do that, it is, again, important to look at total medical cost. If you're looking just, say, at a piece of this pie, if you're looking at just utilization, utilization might go down, and that's good, but if you miss the fact that prices have gone up then you miss the whole picture. If prices go down by utilization goes up you've missed the whole picture. If prices and utilization both go down but quality payments go up you've

missed the whole picture. So I guess all I'm trying to say here is if the question you are solving for is how much does it cost as a whole, is this an intervention that is saving total cost to the system, then you have to look both at the total medical expenses -- and we haven't talked about this yet -- but also, I believe, the trend. If you have low TME but the trend is escalating quickly you still have a cost problem. If you have extremely high TME but low trend you still have a cost problem. So really, when we're looking to see how global payments worked, what we're looking to see in our examination is whether they have worked to lower the total cost of care that we would expect result in a savings to consumers. And I, again, just want to highlight that a lot of the providers here in Massachusetts who've been in global risk contracts have been in those contracts -- you know, we said five or more years, but we're talking 10, 20, 30 years of experience in these contracts, so we do have very ripe information available to really answer that question of whether the total costs of care have been reduced.

Seena Perumal Carrington

Harold, after a theoretically ideal period of five years under a full risk global payment period, don't we come to a point where

all the savings have been run out of the model? Where do we go after that?

Harold Miller

Well, there's a difference when you say all the savings have come out of the model. I think that that takes the static view that says that nothing is going to change in the future, and so why are costs continuing to go up? Well, costs are continuing to go up because patients are getting sicker, because people come up with new and more expensive ways of treating conditions, because people raise their prices because they consolidate and raise prices. There's a lot of reasons why costs can go up, so the question ends up being have you put in things now that will help to be able to address those cost drivers in the future. So if you, in fact, have this kind of a payment approach you take a very different approach to saying, "Hmm, what's that new procedure coming along, and is it actually offering a better value than today?" Because under the current payment model you might say, "Hey, if I can bill for that, man, I'm going to go and do more of those procedures," but on the other hand, if you have a structure that says not, then that may be a bigger control. I think it starts to then put pressure back on the

device manufacturers, on the pharmaceutical manufacturers to not say, “Let’s just figure out how we can sell more product at high prices because we know it will be reimbursed.” We have to start thinking about whether our products actually deliver greater value. So I think that there will be continuing opportunities to save money, because in the absence of doing what we’re going to do there will be continuing drivers for health care cost increases.

Seena Perumal Carrington

For the Geisinger [CABG?] example that you provided on the warranty example, how much less did the purchaser, either the employer or the employee, pay in premiums to the payer that saved 4%?

Harold Miller

Give me the first part again?

Seena Perumal Carrington

In the Geisinger [CABG?] example you provided, how much savings was there for the purchaser in premiums to...?

Harold Miller

I don’t have the numbers here. I know what Geisinger Health Plan saved, and I didn’t include it here, but Geisinger actually has a slide showing that the teachers in the local school system were able to get bigger raises because they were spending less money on premium increases because Geisinger was able to hold flat premiums. So I think that it did go back to the purchasers, and that’s one concrete example of that.

Seena Perumal Carrington

So all of these payment models seem to adjust for patients who are sicker, but what about providers who see a large low income population who may run into other barriers to access in care or complying with treatment? This will reflect negatively on other

providers, though it might be out of their control. How do we adjust for this?

Harold Miller

Well, I think what you have to think about is some of those lower income, more challenging populations also represent even more significant opportunities for savings. So Medicaid patients, for example, end up going to the ER and using the, being hospitalized more often than a commercial population. Why is that? Well, part of the reason for that is because it is much more challenging for them to be able to access good quality care alternatives that will keep them out of the ER and out of the hospital. What you can do with a different payment structure is to figure out how you can actually reinvent the way care is delivered. So for example, under today's fee for service model -- I know Medicare does this, I don't know about your local health plans -- a doctor gets paid less to do two procedures on the same day than to do two procedures on separate days, and a specialist only gets paid if they get an office visit. So I'm sure most of you have had the experience that when you go to your PCP, your PCP gives you a referral to the specialist and you have to go and make a separate visit to the

specialist. You may be asked to come back on a separate day to get something else done. Why is that? Because that's the way we pay. Now, that's a lot easier for somebody on a salary than on somebody who is working on an hourly wage to take off two or three different days of care to be able to go and see those different specialists and to get those different procedures, but if you pay differently then all of a sudden the physician practice has the flexibility to say, "Let me get the specialist on the phone today with you," and be able to pay that specialist for a phone consult rather than only pay through an office visit, and all of a sudden it makes it a whole lost more convenient and accessible for those patients to get better quality care, which could then keep them out of the ER and keep them out of the hospital and save a whole lot of money there, and I think that the flexibility could actually give some providers who serve low income populations even bigger opportunities for reinvention in savings without having to necessarily think about it being more expensive.

Seena Perumal Carrington

You addressed some of this in your presentation, but because we've received several questions I'll ask anyway, and it's also

actually for the Attorney General's Office. So global payments didn't lower payments because of brand negotiation to command a bigger budget, so maybe global payments worked but it's negotiations that are at fault here. And along the same line, is it fair to say that negotiated budgets are a reflection of providers' negotiation skills and/or the provider's market dominance rather than of any actual patient related factors?

Harold Miller

You want to start with that?

Susan Brown

Sure, I'll take first shot. Yes! (laughter) Absolutely. There's no question what our examination shows it that market dysfunction impacts the way that payers negotiate and pay providers. It doesn't matter whether it's a fee for service contract. It doesn't matter whether it's a global risk contract, or any other kind of contract. When you're negotiating prices, market dysfunction is going to impact those negotiations. Now, the good news is that, you know, as a

Commonwealth we're starting to address those market dysfunction issues and how we can move past them, so the question really then becomes if we could somehow wave the magic wand to get rid of those market dysfunction issues, then would global risk payments save money? And that's a question I don't think we can answer yet because I don't think we're in that world yet. That being said, part of what our examination found is that global risk payments are expensive. We haven't talked about care coordination too much today because we're going to talk about it tomorrow, but there are significant expenses associated both with bearing risk and with coordinating care, and I hope you will read the pre-file testimony. I think providers here did a very thoughtful job of really laying out all those different expenses, and so what remains to be seen, I believe, is if we experience gains in utilization, as laid out by Harold Miller, will those gains be offset by the expenses associated with that different type of methodology? And it's something I think we still have to wait and see.

Harold Miller

You'll notice on my list of elements that affected price control the word "negotiation" does not appear, because I think that

fundamentally the notion that you control prices by having negotiations between big health plans and big providers doesn't work, because what happens is everybody just tries to get bigger, and we've seen what happens in the end. The biggest health plan in the world is going to lose against the biggest provider in the world if it's the only provider that is out there, and so that's why it is really important to have a choice of providers, and it is important to have consumers being able to make those decisions themselves. The reason why that Minnesota model I talked about worked is because it gave complete choice to the providers. There was no negotiation whatsoever between a health plan and those providers. The providers got to set whatever price they wanted to. If they wanted to set an incredibly high price, they were welcome to do that. The thing was, the consumer was going to pay the difference. That was an effective break on them, because when the consumer said, "I ain't paying that price! You're not offering that much better care! I'm leaving." And so one of the things I think we have to be very concerned about is to give choice is that we don't sort of raise the bar so high and say the only entities that can do this have to be big entities that own all their doctors and have massive EHR systems, because that will reduce the number of choices that patients have, and

reducing choice means reducing competition, which means that we will not succeed.

Seena Perumal Carrington

Thank you once again, Harold, Stacey, and Susan. We'll actually take a very short break and reconvene in this room in five minutes prompt, surely, to begin with our panel discussion.

[irrelevant audio omitted]

[break in tape]

Seena Perumal Carrington

If everyone could just take their seats, please, and if all the panelists could just join us at the front. OK, thank you. So we're going to begin by swearing in the panelists, so if you could all rise, and the moderator, as well. Thank you.

Harold Miller

Notice I’m getting sworn in after the presentation. I’m not sure exactly what that means. Can I do a retroactive swear-in? (laughter) I swear that everything I said previously was true to the best of my...

Seena Perumal Carrington

Appreciate it, Harold! Can you raise your right hand? Do you solemnly swear that the testimony you’re about to give in the matter now at the hearing will be the truth, the whole truth, and nothing but the truth, so help you God?

Panelists

I do.

Seena Perumal Carrington

Please identify yourself by raising your hand if your testimony today is limited for any reason, if there are any restrictions placed on the capacity in which you testify here today, or if you have any conflicts of interest that require disclosure. So with that, let's get started. Thank you.

Harold Miller

OK, so I'm your now sworn in (laughter) and volunteer moderator, I guess, in the spirit of full disclosure, so if anybody thinks I'm getting paid to do this, this is purely voluntary on my part to try to help the state move forward on this, and we have five additional experts to help who are going to, I guess -- it's labeled response panel, but I would not suggest that they're going to simply respond to me. I think they have a lot of their own thoughts that they want to share. So they're going to get five minutes each, and I am going to -- when your time is up you will notice that I suddenly start clearing my throat. To any physicians in the audience, don't worry, I am not dying up here, and the longer you go the more I will clear my throat to the point where no one will be able to hear me anymore, and the guy

in the front will start giving you a warning and that's when I will start clearing my throat. So I think we're going to start, and then we will have, I think, some questions, you can ask questions of them. I will be moderating some discussion and asking hopefully some challenging questions of my own. So we're going to start with David Polakoff, who is Director of the Office of Clinical Affairs, MassHealth Chief Medical Officer, Center for Health Policy and Research at the University of Massachusetts Medical School.

David Polakoff

Thank you, Harold, and thank you, Commissioner. Pleasure to be here. I've been asked to make a few remarks addressed at the question of, surrounding the Massachusetts Patient-Centered Medical Home Initiative and whether it is working to lower the cost trend, and the short answer to that question is we don't know yet. The slightly longer answer is -- I'll give you a brief explanation of what we are trying to do in this multi-payer initiative and how we hope to determine whether it is working to lower the cost trends.

The initiative is too complicated to explain in one out of my five minutes, but briefly, we are trying to build competencies in primary care practices. This initiative just began a matter of weeks ago. It involves 46 primary care practices across the state that cover the primary care specialties of internal medicine, family medicine, and pediatrics. The 46 practices are an average size of about five FTE practitioners, so it is touching over 200 primary care practitioners across, geographically distributed across the state. And its goals are to redesign the practices in the following three areas that you see on the slide. There's the area of practice redesign, the area of consumer engagement, and then clinical care management and care coordination. Patient centered medical homes in and of themselves are not really designed to save money. They are designed to build the skills and transform the way primary care is delivered in order to pave the road and form the foundation for accountable care, for global and bundled payments, to prepare the delivery system for the future state, and so that's what we're trying to do. We're trying to demonstrate that it can be done in a large number of practices across the state. This initiative involves essentially all the major payers in the state, so it is a multi-payer initiative, and as a result it's quite complicated and it took almost two years to bring all the stakeholders together and to formulate the details.

So how will we know whether it is working? Here are the fundamental evaluation questions. A formal evaluation plan has been developed and will be implemented as the initiative goes forward. It's baked into the initiative. We want to know to what extent and how do practices become medical homes. How do you measure medical homeness on a continuous scale? To what extent to patients become partners in their own health care? Patient engagement, as I think you heard from Harold Miller's testimony, is key to saving money. Patients have to have a stake and they have to become involved. And what is the initiative's impact on [utilization?] cost, clinical quality, patient and provider outcomes?

Here are the sources of data we're going to look at. We're going to interview practice facilitators who are guiding and coaching the practices in their transformation efforts, as well as the practitioners. We're using a survey, TransforMED, which is -- TransforMED is a subsidiary of the American Academy of Family Practice. It helps practices transform into medical homes. They have a formal survey; we're going to apply it. We'll review lots of documents from the practices. There's a patient experience survey that's based on NCQA's new medical home caps instrument that will be applied and we'll gather data

there, and there will be a claims analysis, of course, and then we'll be surveying staff, as well. So it's a multi-stakeholder kind of approach to evaluation.

Well, has it worked compared to what? That's probably the most critical question. We're going to develop a matched group of non-participating practices in Massachusetts to which they'll be compared, and they'll be matched on all of the factors that you see in the slide. I won't read them to you, but essentially it's size of the practice, it is the type of practice -- there are a whole wide variety of different types of practices; we'll try to match as best we can -- their location, their specialty, and so on.

We'll be looking at measures across a number of domains. The first is clinical quality prevention. Are they doing more preventive care than they did previously or would have otherwise? The second is clinical quality acute and chronic disease management. As you've already heard in earlier testimony, a lot of the projected savings that might come from medical homes arise out of better management of chronic disease, and so we'll be looking at some specific areas, including comprehensive diabetes care, as one of the index conditions. Depression management, behavioral health costs are a key part of

the redesign effort. The use of appropriate medications for patients, particularly children, with asthma. Follow-up care for children who are prescribed ADHD medication, a key clinical quality issue, and then pediatric obesity and hypertension are some of the key areas.

The patient experience survey will look at patients' satisfaction with the care they're receiving. If the patients don't appreciate the changes, this effort is probably not going to be a successful one that will spread. Are the practices, which are redesigning their care, more oriented toward the whole person? Do they make shared decisions with the patients and involve the patients in clinical decision making, as well as the families, and have they built in support to allow patients to do more self management? There are a couple of access measures. The practices are encouraged in their own individual and unique ways based on their own circumstances to enhance access with increased use of telephone care and changes in hours, electronic and e-mail care, and so on.

And finally, we'll be looking at service use, and this is the, from a cost perspective, the ultimate outcome measure. And some key areas of service utilization will be emergency department visits, hospitalizations for ambulatory sensitive conditions,

for conditions that could have been managed in a non-hospital setting, the readmissions, overall total medical expense or total cost, primary care visits, specialist visits, and high cost imaging. And I think that concludes my... The stop sign came up, perfectly timed! Thank you.

Harold Miller

I think he was a little generous with you, but that's OK. (laughter) Next we're going to hear from Evan Benjamin from Bay State Medical Center.

Evan Benjamin

It's a pleasure to be here today to share our work regarding an alternative payment strategy. Today I'll discuss Bay State Health's experience with a bundle payment prototype. Bay State Health is an integrated regional health system consisting of a tertiary referral academic medical center, two community hospitals, an employed physician group with over 500 providers, our own visiting nurse association, and a health plan consisting of 120,000 members, Health New England. Our focus has been on

achieving the highest quality and patient safety for patients of Western Massachusetts.

Two years ago we began making the concepts of the triple aim the foundation for the work which we're doing. Our past focus has been on having excellent patient experience, including quality and safety, but as responsible members of our community we've recognized we also need to concern ourselves with lowering the overall cost of health care, as well as to pay attention to the overall health of our population. Our program where we sought to bring together the concepts of improved quality and efficiency was our first bundle payment program. Because of its simplicity, we modeled this after the Geisinger model that you heard about earlier. A bundled payment program is an integrated model of care that delivers improved quality and value for a particular disease-based service. Payments are bundled together for physicians, hospitals, and other providers. The program brings together providers to improve quality and efficiency and aligns the interests of all the providers by focusing on an episode of care over a defined time period. Incentives for quality and cost reduction can be part of a bundled payment program.

We called our program the Bay State Best Care Program, and our first prototype was total joint replacement. Our goals were to create a more reliable, more efficient care delivery process and to maintain predictable costs. We sought to understand the complexities of creating a bundled care program, and to make it scalable so that we could adopt this for other clinical areas.

We had certain assumptions when we started our program. First and foremost, the payment for care for the doctors in the hospital going forward would not increase during this time period. There would be a guarantee any preventable complications would not be billed to the health plan. We created an upside shared savings model for the doctors, the hospital, and the visiting nurse association. There was no downside for risk for higher cost outside of those in the bundle. We also realized that we did not need to prospectively manage this. We would track fee for service experience and then retrospectively reconcile the payments against the bundle and calculate any shared savings. We brought together providers to collaborate on the project. The physicians were non-employed physicians in our community. The health plan, the hospital, and our VNA came together. All the leadership created a collaborative group, and then we developed three work groups:

one group to work on the care models, one on the payment models, and one on infrastructure in terms of data.

The bundle for total hip replacement is conceptually illustrated on this slide. The model of care group redefined the processes of care with the intention on achieving improved quality as well as improved patient engagement while decreasing the utilization units, shown in yellow on the slide. So for example, the model of care called for lower length of stay, lower inpatient costs, a reduction in post-acute care rehab, and more home care rehab. The overall cost of care for the bundle, the doctors, and the hospital and rehab care would remain the same in 2011 as the costs were in 2010 and you see here at $24,000. The teams came together, and based on best practices they identified stretch goals for the percent of patients that were discharged to home, length of stay goals, inpatient cost goals, as well as goals for quality, patient experience, as well as functional status were also established.

The bundle included all the pre-op history and physical through the third post-op visit. Patients received a compact when they enrolled in the budget, which highlighted what were the care expectations and what were the patient behaviors that would help achieve the best outcomes. Clinical care changes included a

prehab visit that would help strengthen patients prior to surgery, as well as specific protocols for the visiting nurse association, for post-op rehab, and specific planning to avoid post-acute care rehab stay. Quality measures were hardwired to achieve perfect care.

The results have been actually very encouraging. These data represent the first 30 patients of the program. Improvements in readmission rates, quality measures, and patient experience were all observed, as you can see on the table. The most notable results have been that 100% of the patients have gone home rather than to a post-acute care rehab, and that overall cost of care have fallen for the entire bundle by greater than $2,000. The costs were lowered as a result of two major areas. One was avoiding post-acute care rehab, and also lowering inpatient costs of care as a result of decreasing specific utilization in the inpatient side.

We've been able to improve the quality of care, the patient experience, and lower the cost of care in this bundled payment program. The physicians have been extremely engaged, and the incentives to align them were actually very simple and very easy to create. We did spend a lot of time trying to determine which services were in the bundle and which services were out of the

bundle, and this took lots of planning. The politics were a barrier, and even though this was our own health system with our own health plan, we found that determining the goals as well as the funds flow were actually quite complicated, but we also found that if we focused on quality and we were transparent about the data, we were able to engage all the providers and end up with the win-win-win that you heard about earlier.

I will leave with you just some thoughts from Michael Porter in his recent article in the *New England Journal* talking about how do we assess value in health care, and that he talked about improving value we must understand the quality and cost of an entire episode and what that means to a patient, and that the unit of reimbursement needs to be aligned with this unit of value. By bundling the cost of care in this situation for the entire total hip replacement episode, we were able to improve quality, decrease costs, and improve the patient experience.

Harold Miller

Thank you, Evan. It occurs to me we should have sort of simulated the notion of the warranty payment today by having a fee for every minute over five minutes (laughter) that we went

over, and a bonus for a reduction, and seeing whether we would have all behaved differently under that kind of model. So next we're going to hear from Joseph Berman from Acton Medical Associates, who is welcome to stay -- you're welcome to stay at the table.

Joseph Berman

Yes, I don't have slides today, so following the --

Harold Miller

Pull the microphone close to you, pull the microphone close to you.

Joseph Berman

-- following the format from yesterday, if you'll indulge me, I'll stay away from the scary podium. Good morning, Mr. Miller, distinguished leaders of the Commonwealth, fellow panelists, and guests. My name is Joseph Berman and I'm here today

representing the physicians of Acton Medical Associates, PC as their Chief Operating Officer. Thank you for giving me the opportunity to participate in this crucial discussion.

Acton Medical is a physician owned and managed group of 23 primary care physicians, employing 200 support staff and serving 45,000 patients from the towns of Acton, Littleton, Harvard, and the surrounding communities. Acton Medical has been in practice for more than 50 years and has a history steeped in physician managed, high quality, and effective care. Recently, Acton Medical was recognized and honored by NCQA as a Level 3 certified patient-centered medical home. Deborah Kovacs, Acton Medical's Medical Director and CEO, has asked me to deliver the following message regarding health care cost trends.

At Acton Medical we have watched with alarm the rising cost of health care. We share the concern of the Commonwealth that these costs are affecting residents at all levels. Businesses must divert more resources to providing health care to their employees. We see this directly as the cost of providing health insurance for our own employees has risen significantly each year. Employees must use more of their personal income to cover high premiums and copays. High deductible plans encourage patients to avoid care when they need it. We hear this daily as

our patients decline diagnostic tests or medications since they feel they cannot afford them. This is a worrisome trend. We feel that basic health care services must be covered and must be affordable for everyone.

Although we do not pretend to have all the answers to controlling health care costs, we are confident that we know some essential factors that can help. We feel that the basic critical factor in controlling health care costs is the primary care physician. Our practice has a tradition of providing primary care. Our physicians are fully invested in making sure our patients receive excellent care, as well as cost effective care. For health care costs to be controlled, every patient must have a primary care physician who directs their care. PCPs are in the best position to manage the care of their patients in a high quality, cost effective, and appropriate manner. Physicians have the tools that they need to effectively direct the care of their patients. As such, we fully support the Attorney General's call for mandated PCP selections for all PPO members. A patient presenting with a routine problem can be taken care of by their PCP without needing specialty care at a low cost. PCPs deliver, develop relationships with patients, which encourage compliance and trust. PCPs encourage patients to adopt good health habits, thereby avoiding preventable

diseases such as heart disease, diabetes, and high blood pressure. Primary care physicians enact quality programs for preventive care, ensuring patients stay healthy and that problems are detected early. Early detection of cancers also decrease health care costs as these cancers are more easily and effectively treated. When a patient needs specialty care, the PCP knows best when to refer. Generally, that PCP will refer to a local specialist in the community, ensuring cost effective and excellent coordination of care. Patients self-referring to a specialist often take an expensive and [circuitous?] route to the ultimate diagnosis and treatment plan. For example, a patient with back pain may, might seek care from an orthopedist, a neurologist, and a chiropractor, going through various scans and treatment regimens. A primary care physician, by contrast, would be able to assess the problem initially. With the training and the time to explore different diagnostic possibilities, the PCP is more likely to come up with the actual diagnosis of an aortic aneurysm, referred pain to the back, along a much lower cost and less complicated trajectory. The PCP can then institute a preventive plan of stopping smoking and treating high blood pressure, hopefully preventing a catastrophic rupture of that aneurysm.

(loud throat clearing; laughter around room)

ACOs have recently been in a lot of press. ACOs should be protected, and those who participate in ACOs should be protected from the extraordinary cost of catastrophic care. Since the primary care physician can no longer manage care and cost in those situations, patients should be rewarded for taking responsibility in their health through incentives, through staying healthy, and engaging in preventative services. These nominal costs will be well worth it. Primary care physicians will be empowered to control health care costs in the ways that they are uniquely prepared to do through high quality, cost effective, and patient centered care. Dr. Kovacs was grateful to participate in this, as am I. Thank you.

Harold Miller

Thank you. Next is Patrick Gilligan, who is Senior Vice President at Blue Cross Blue Shield in Massachusetts.

Patrick Gilligan

Thank you, Harold. Good morning, Commissioner Carrington, Assistant Attorney General Brown, our distinguished moderator, and fellow panelists and guests. My name is Patrick Gilligan, Senior Vice President for Health Care Services at Blue Cross Blue Shield in Massachusetts. Thank you for the opportunity to participate in these hearings. I want to start by commending the Governor, the Attorney General, and each of you for your sustained attention to the issue of rising health care cost, which we all agree is now one of the pressing issues facing families, businesses, and state and local government here in Massachusetts. As you know, Blue Cross Blue Shield in Massachusetts, like other local health plans, spends about 90% of each premium dollar we collect on medical care for our members, with the remaining 10% going towards the cost of running our business. We pay careful attention to our administrative costs and anticipate that our 2011 spending will be at or below 2008 levels. That said, the majority of our effort is necessarily focused on medical spending.

We believe there are many strategies to reduce medical expense, and any successful attempt to control cost will need to include a combination of approaches involving all stakeholders. One such approach is using product design to engage members and employers in managing the cost of care. Blue Cross Blue Shield

in Massachusetts has a new suite of products which allow members to choose any provider in our network and pay a low copay for most care in most settings, or higher copays for care and higher cost and/or lower quality settings. These products have been very well received by our customers. In fact, one product, which call Hospital Choice Cost Share, is the fastest growing product in our company's history. Another strategy is to help members better manage their health and chronic conditions, leading to healthier lifestyles and reduced need for costly medical care. A third strategy is developing payment models which reward the value rather than the volume of care. We believe that this is the best and most sustainable route to improve health care quality and control cost. There are many different ways to design an alternative payment model. Blue Cross Blue Shield in Massachusetts has been a market leader in developing, implementing, and supporting one such model, which we call the Alternative Quality Contract, or AQC. The AQC is a five year voluntary agreement that combines a per patient global budget with significant performance incentives based on nationally endorsed quality measures.

We developed the AQC on our own initiative, in a time when it was clear that the status quo was unacceptable, but also that overcoming the barriers to change would be very challenging. We

were asking providers to do something totally new: to be responsible for the total cost of their patients' care and to do it for a sustained period of time. The global payment models that existed before that were one year deals, and each year the providers had the opportunity to come and renegotiate, and these are the first long-term contracts in this market and maybe across the country. We also had to overcome concerns about prior global budget models, such as capitation, that set provider budgets too low and ultimately failed. Given this history, we are very encouraged by the AQC's progress so far. Currently the AQC includes 12 provider groups across the Commonwealth who care for approximately 45% of our HMO members. Data from the first year of the AQC shows that groups are changing the way they deliver care, and that these changes are improving both the quality and efficiency of care. In terms of cost, AQC groups are on track to reduce annual health care cost trends by one half over five years. This was the original goal of the AQC. Our goal was not to establish budgets such that they would be lower than others in the marketplace but instead to bend the trends over the five year period, and that is happening. In terms of quality, the AQC groups produced the greatest one year improvement ever seen in our provider network. Because the AQC is structured to encourage investment and long term planning, we expect to see even stronger results in the

later years of these five year contracts. We believe that the combination of these approaches, including the AQC, tiered products, and sustained attention from employers in so many state agencies is beginning to change the Massachusetts health care market. Taken together, they have created pressure on all providers, including the most highly paid. Our ongoing negotiations with providers across the state are showing positive signs of further progress towards improved affordability. This is a positive sign, but I want to emphasize again that we must continue to pursue multiple approaches, to engage all stakeholders, if we are to create sustained release from rising health care cost. Blue Cross is ready to work with all of you as you continue to develop and implement ways to achieve this critical goal. Thank you for your consideration on these important issues, and I look forward to the panel discussion.

Harold Miller

Thank you, Pat. You get a bonus for actually beating your time there. (laughter) What will the State pay us, about? (laughter) And last but not least is Nancy Kane from the Harvard School of Public Health.

Nancy Kane

Thank you. I'm going to piggyback everybody's greetings and gratitudes so that I don't use my five minutes to say thank you.

Harold Miller

No, that part's exempt. You're allowed to thank everybody and greet the State and that doesn't count.

Nancy Kane

(laughter) Oh, he's counting, I can see it right now. (laughter) Also, I wanted to say that I think Harold read my testimony before he prepared his talk, because I very much agree with everything he said, in particular that payment incentives are very poorly aligned with affordable, high quality care, and it's not just the unit of payment, it's also the rates of payment, and they're not serving our population very well. I also observe that we've had the structures in place for many years to

try to do something about this. We've had integrated delivery system, at least theoretically integrated. We've had PHOs, IPAs, multi-specialty group practices. Those have existed for many years. So one question I why haven't they gone forward to create these more innovative, you know, suggest to try to provide more integrated and seek more alternative payments that reward them for integrating care and taking better care of the population? And I think we really need to examine that to be meaningfully able to reform our current payment environment.

So one of the biggest challenges is that the people who won big in fee for service don't want it to change, and they also have the most resources to resist it, and until, I think, the Attorney General's Office takes market, you know, enforcing excess power in the marketplace seriously and comes up with meaningful solutions, it's very hard to impose a solution that really is an equitable and fair one for everybody. Another is that, you know, consumers -- I agree with Harold that consumers do need to have that last dollar coverage responsibility. Those products are just starting to show up on the marketplace now, and you kind of have to wonder what took so long. Why is [BCAG?], which was one of your great examples of a perfect, you know, the ideal involvement of consumer choice, still only a tiny percentage of the market in Minneapolis, in Minnesota.

BCAG tried to start a product here and was unable to do that because of provider resistance. We do have to address the forces that don't want to see the kind of alternative payment systems that so many of us have been advocating for many years.

I think the whole issue that it does require big upfront investment in IT, in leadership, in education, in care protocols, I think our panelists gave us some good examples of the kind of expense this takes, is a deterrent, particularly because the payers haven't guaranteed that they're going to get a return, and one payer might say you'll get a return on my little segment of HMO patients but all my PPO patients and everybody else, ha, ha, ha, but the incentives are completely the reverse and you're not going to get a return. So having the incentives mixed, having the terms of any contract by one year or three years, all creates huge uncertainty out there on the part of providers trying to make hundreds of millions of dollars of investment. The Medicaid patient population constantly churning in and out of Medicaid. How do you put a big investment into taking care of a Medicaid population that isn't very constant and keeps moving in and out of different payment plans. So I think it's very hard to take $100 million bets on an infrastructure to manage care and prove quality when your future is totally cloudy and there's no certainty on going out

more than three to four, or even five years, frankly, because the returns are going to take longer than that. It's not just the time it takes to get the returns, but it's the mixed payment systems. So yesterday, one of my faculty who's involved with the provider systems said, you know, we're still debating whether we should invest in the very remunerative types of procedures that fee for service has historically rewarded, or whether we should just check all that and really assume the payment system is going to go towards keeping people well and not needing extra highly profitable procedures and imaging and diagnostic tests. So they don't know what to invest in right now. The signals are so mixed up that it's very, very hard to get the providers to act in the meaningful direction with an alternative payment system.

Another big uncertainty: our hospitals that are very capital intensive are very much not aligned many of times with their physicians, and if physicians -- I would like to see physicians take charge of the global payment, but if they start saying, well, we're not going to share the rewards with our hospital partners, you're going to see a lot of disruption, resistance, and problems in the long run, and they're not going to work out so well. So I think there's a real need to start thinking about the political implications of how the payments inside the

capitation get allocated out and whether they are really in the best interest of our long term delivery system's health and our population's health.

The research and teaching are huge issues, as I think the (inaudible) report shows -- something like two-thirds of our patients go to teaching hospitals for most of their care, and one of the nice things about that is that patient, those clinical revenues support both the research mission and the teaching mission. Research does not pay its way and the teaching doesn't either. And so what happens when you start to reduce the revenues that go towards hospitalizations and divert it to other things or actually lower the overall costs? So we haven't thought through how do we pay for the research and teaching mission, how much of it should we be paying for. Massachusetts is a great national resource, but do we really want our patients -- how much of that should we have our patients be paying? How should we try to find other ways of having society support research (inaudible) that doesn't just all fall on the state residents.

(Harold clears throat) (inaudible) I'm done. Big upfront infrastructure, really another big group that we have to worry about our safety net, hospitals that have much more difficult

populations to pay for and we haven’t fully thought out how to do socioeconomic adjustments. And my last point is I really think we need an independent oversight body to make sure that the game that we want to set out is really played according to the rules that people believe in and trust and result in better quality, more affordable care for the Commonwealth. I took his minute, too. Thank you.

Harold Miller

I was going to show, you should’ve actually bought the minute from Patrick, and then you would’ve been able to --

Patrick Gilligan

You said we get a bonus.

Harold Miller

Right, assuming you get a bonus, yeah, you could trade it. That’s the way this works. So I want to ask some questions to

you, and get your responses, and I'll pick up on one of the things that Nancy said, which is that the future is cloudy. And all of you really talked about what you're doing today. I want to talk about where do we want to try to get to. And despite the efforts that are being done today, the dominant model today is still fee for service. So the question to each of you is in five years what do you think the dominant payment model in Massachusetts should be -- not what it will be, but what do you think it should be in five years? Start with David. No wishy-washy answers, either. I want straightforward, crisp. (laughter)

POLAKOFF: Is that a multiple choice question? (laughter) A, B, C, or D? In five years --

MILLER: Pull the microphone a little closer.

POLAKOFF: Sorry. In five years I believe that we need to have made substantial progress toward some sort of, to use the old terminology, global payment system -- I think those probably will still be mixed. It won't be -- the job won't be complete, but I hope and think we should have moved along --

MILLER: So does that tell me that the dominant payment model should be in five years global payment?

POLAKOFF: Yes.

MILLER: Yes, OK, great. Evan?

BENJAMIN: I mean, I think we're still going to have lots of different payment models, and I think we need to have different payment models, because to me this is a manner of having different incentives at different times. If, in fact, you were an entirely global payment model, people game that system as we've been concerned about and talked about. If we are an entire system that is fee for service, you know, we're gaming that for volume, we need to have different ways that we can dial up and dial down the incentives so that we can balance all of the incentives so that we make sure there's no gaming of the system, that we're measuring quality. The measurement of quality needs to be a huge part of this, and right now --

MILLER: This is bordering on the wishy-washy here, so...

BENJAMIN: I want to [hear?] --

MILLER: So are you saying that you think there should be no dominant payment model in five years, or are you saying that you think that the dominant payment model should be global but that there should be some other options out there?

BENJAMIN: I think the dominant, the payment model will have multiple different approaches, that the model will probably have four or five different ways -- we'll have some pay for

performance, some episodes of care, some fee for service, and some --

MILLER: And none of them will be dominant.

BENJAMIN: And none of them will be dominant.

MILLER: OK, and you think that's a good outcome?

BENJAMIN: I do, because I think we can dial up and dial down the different incentives in each of those.

MILLER: OK. Would you change your answer if I asked you about ten years? Or do you think that that's the way it should always be?

BENJAMIN: Is everyone else going to have to answer for ten years, too? (laughter) I think it will be different in ten years. I think in ten years it will be more --

MILLER: What should be the dominant model in ten years?

BENJAMIN: I think we'll be closer to a global payment system in ten years.

MILLER: OK, great, Joseph.

BERMAN: I'll answer both with the five and the ten year, and just simply say that global payments, I think, are important. PCP managed global payments, there should be stop loss coverage for those taking on those global payments, and quality rewards packed into it.

MILLER: So, I mean, we need to make sure it's the right global payment model, but you're saying that you think it should be the dominant structure.

BERMAN: Yes.

MILLER: OK, Pat? Five years.

GILLIGAN: You probably won't be surprised to hear me say that I think global payments should be the dominant model in five years. I think it should have some of the elements that Joe just mentioned but also have risk sharing and not just be totally transferring the risk to the providers, and what we want to do is have alignment between the payer, the provider, and products for the members so that everyone's incentive is to increase the quality and reduce the cost.

MILLER: OK, Nancy.

KANE: Well, the five year I'm with Evan. I kind of think it's going to be a mixed bag because a lot of places aren't going to be at global payment and you don't want to force them there before they're ready, but in ten years (overlapping dialogue; inaudible) --

MILLER: I didn't say will, I said should. I said where do you think it should be in five years.

KANE: Well, the should doesn't... I have a should problem. If it's not feasible I don't go for it, so I think bundled, heading toward bundled in five years, everybody should be

at some form of bundling and learning how to do it, and by ten years everybody should be more than ready, past ready to just have global payments.

MILLER: OK, so somewhere between five years from now and ten years from now we should be at a dominant model of global payment. So the second question for you is what do you think the biggest, one biggest barrier is to being able to get there? Single biggest barrier, and what would you do about it? And I'll start with Nancy.

KANE: I think creating the trust in the provider system that it'll work and in the patient population that they won't be skimped on, so --

MILLER: Mm-hmm, that's the barrier?

KANE: Yeah, I think --

MILLER: What would you do about it?

KANE: What would I do about it? Well, I think a lot more --

MILLER: No escaping by simply listing problems here.

KANE: No, actually, I'm happy to try to do it. I mean, I think a lot more transparency around cost and quality is really a lot of it, and having a lot more accountability, better ways to measure what's happening that people actually believe in.

MILLER: So this is trust about both sides understanding what the numbers are and how the numbers work so that whenever you strike a deal that it's sort of fair, is that...?

KANE: It's fair and equitable, and, you know, again, I'm back to needing some kind of an oversight body to make sure that does happen, because I think if you just leave it to chance it won't happen.

MILLER: So you think the way to have trust is to have oversight.

KANE: Trust with oversight, oversight that encourages trust. (laughter)

MILLER: OK, interesting. Interesting model. (laughter) Sort of we'll require you to trust each other, right? OK, Pat.

GILLIGAN: I'm having trouble narrowing it down to one. I would note --

MILLER: I figured you would.

GILLIGAN: -- two big barriers in my mind. One would be Medicare, to the earlier points. If global payments or any payment methodology's going to work we don't want providers to have different incentives through different payers and question whether or not --

MILLER: OK, so the barrier is having different payment systems from different payers, and particularly Medicare.

GILLIGAN: Well, Medicare is one, and the other I was going to note is around PPO products in the commercial market. And so right now that is an obstacle of getting to global payment, and I think we have a lot of work to do with employers in particular around the value of moving members to global payment and picking a PCP.

MILLER: So you don’t think global payment works within a PPO model?

GILLIGAN: I think there -- I have concerns about it in a PPO model.

MILLER: OK, we’ll come back to that in a couple minutes. OK, Joe, biggest barrier to getting to that.

BERMAN: The single biggest barrier, I think, is public acceptance of the return to directed care, and the legislative support --

MILLER: Return to directed?

BERMAN: Yeah, directed care, and the legislative support for those systems.

MILLER: OK. So you think it should be portrayed as directed care? Doesn’t sound like as if that’s a natural selling point for consumers to be... (laughter)

BERMAN: Right, and, you know, I think --

MILLER: Nancy’s going to mandate trust, and you’re going to direct care.

KANE: Oversight to ensure trust!

MILLER: It’s no wonder we don’t have global payment in Massachusetts! (laughter)

BERMAN: You know, the harsh reality is that, you know, patients are not trained in medical procedures or diagnostic, in establishing diagnostics, and so to have patients trying to self-direct, which is part of the problem today, rather we need to have physicians involved in the care. Transparency works well for patients to choose where they’re going to have specialty care or hospital care, have their procedures done. I think that that’s part of the global system that will work well, but in terms of managing the population I think it has to be managed by physicians who are trained in those services, and, you know, it may not be the most pleasant word but --

MILLER: But you -- I thought you had said that you thought patients should be engaged in their care.

BERMAN: They should be engaged in their care with the primary care physician. Again, patients can’t diagnose themselves.

MILLER: OK, so --

BERMAN: They need help, and the primary care physician is the one who is going to establish that relationship, establish that trust, and then, collaboratively with the patient if appropriate, help to direct the care. And again, using

your model, if, once the care is being directed, the patient has opportunities to choose where they're going to receive that care, I think that that would work well in bringing down the cost.

MILLER: OK, so barrier is getting patient acceptance and figuring out how exactly we explain to the patient what this is we're going to do differently and why it should be a good thing for them is really what we got to figure out how to do.

BERMAN: What I see with our patients at Acton Medical is, especially in the PPO model, the patients don't select a primary care physician. They self-direct their care directly to specialists, directly to teaching hospitals, assuming that that's where the best care is going to be. That's part of the problem, so reining in, if you will, that patient's belief that they can best direct their own care at that primary care level I think is critical for global payments to work.

MILLER: OK. I would point out that I think a lot of patients are self-directing their care because they think they're not getting very good time or guidance from their practices, which is a function of the way we pay, but Evan, biggest barrier?

BENJAMIN: I would say the biggest barrier we have is the lack of current integration and coordination of our health system. To actually do this, to be successful in a global payment model, we are going to have to figure out how do we integrate our health care system. How do we create integration? How do we understand population health? A system approach to care -- how do we have the data to understand not only what our patients are but predictive modeling of what they're going to do? We don't have any --

MILLER: So is data the real barrier?

BENJAMIN: Well, it's... I would say integration is the big barrier, but data is a huge tool that we just don't have right now to create an integrated delivery system.

MILLER: So what -- OK, so what -- maybe I should ask the solution -- is the solution better data, to be able to get better integration?

BENJAMIN: Data's an essential component to create an integrated system, but it's right now, our current system does not support --

MILLER: And when you say integration do you mean consolidation into one organization, or do you mean coordination of care?

BENJAMIN: I mean coordination of care. People can be in separate organizations, but better coordination, better communications.

MILLER: So it’s hard to manage a global payment if you don’t have coordinated providers, and it’s hard for them to figure out how to coordinate better if they don’t have information to support that. OK, David, biggest barrier.

POLAKOFF: I’m going to pick up on what I think is the flipside of what Evan was just saying, and that’s, I think --

MILLER: Pull the microphone a little closer.

POLAKOFF: -- a big part of the barrier, what would be perhaps the biggest barrier, is what they do with the data. Even if we had the data, the development and dispersion of the skills and resources needed to manage performance risk through the provider community is, I think, still liking.

MILLER: And the solution is?

POLAKOFF: The solution is that I think there’s going to have to be significant investment in that area, and where that comes from, I think that is an open question, but whether --

MILLER: Investment in training, in...?

POLAKOFF: Yes, in training, probably in larger provider organizations, in staffing with new skill sets.

MILLER: OK, and so the question is if that requires money, where does the money --

POLAKOFF: Where does it come from?

MILLER: -- where does the money come from? OK, so we need to be -- we should be with global payment in five to ten years. We've got some barriers, potential solutions. So how do those barriers get overcome? Is this the state needs to fix this? Does the state need to mandate it? Does the state need to regulate it? Or can this be done on a voluntary basis by all the stakeholders in the community working together? I'll start in... I don't know, I'll start in the middle. I'll start with Pat.

GILLIGAN: I think we would say that the market's starting to move in the right direction, and that we are engaging providers and we are engaging members and getting them aligned, and our preferred approach would be to use those products and the contracts that we have to get us there. Again, as I stated in my testimony, we already have almost half of our network in a bubble payment in just a few short years. I don't want to predict now what will happen in the coming years, but I can tell you that, you know, most organized provider groups in the state are talking to us about our alternative quality contract, and two or three years ago most of them said they would never consider it, so (overlapping dialogue; inaudible) --

MILLER: So what's the state role then? Is the state role to just sort of trust that it will work and sit back and wait,

or should the state say, “Here is the deadline and we won’t do any -- we’ll let you try it on your own until you prove you can?”

GILLIGAN: Well, I do think the state could be supportive. I didn’t mention Medicaid as a barrier, only because it’s a smaller piece of the population --

MILLER: You keep wanting to give me more barriers, don’t you? (laughter)

GILLIGAN: But the state could help by using a similar model in Medicaid, help us in CMS in terms of a potential waiver and doing something around Medicare.

MILLER: Mm-hmm, OK. State role, David.

POLAKOFF: Well, I think we all, or most of us, tend to have a bias against state mandates, but I think the State has a clear role here that would probably include setting some rules of the road, some parameters for what this will look like, allow the market to develop the concept and some variations on it, but define terms --

MILLER: What would a rule of the road look like to you?

POLAKOFF: I think some of it comes down to setting some limits on, or some boundaries around what we define as a global payment, what it can be for, what it can’t be for, and then also setting the transparency standards. Some of the barriers that were discussed were around data and

transparency, and I think the State has a role in creating the vehicles for transparency.

MILLER: So first is sort of trying to maybe allow some flexibility but say what can't be counted as being progress and having some way to get data and information out, available to people.

POLAKOFF: Yes.

MILLER: OK. Evan, so you were one of my first ain't going to happen in five years people, so what should the State role be?

BENJAMIN: Well, if I follow up on my last comment about the need to really overhaul the health system in terms of how do we create a truly integrated health system that we're going to need to reduce costs and improve quality, what we need to do is have the right incentives upfront, because this is expensive. Everything in terms of IT infrastructure, communication, and to actually change behavior, we're going to need to have incentives, and I think people respond to incentives. So whether that's upfront infrastructure payments from the State to begin the process to have, lay the groundwork for data systems and IT --

MILLER: So you want the State to pay for your infrastructure.

BENJAMIN: Well, I think we're -- you know, I think long -- the incentives need to be there, either as a result of a shared

savings or pay for performance, but I think we're going to have a hard time overcoming all the barriers we've talked about without having those aligned incentives.

MILLER: So you don't think you could save enough money in the short run by focusing on things like readmissions, et cetera, to actually be able to pay off some of these investments without having the State give you money upfront?

BENJAMIN: You know, in the short term, you know, as we see now, we've been very aggressive in our health system to decrease readmissions, and because we felt, as I mentioned, that trying to align ourselves with the triple (inaudible) was the right thing to do, but in the current fee for service system we're actually hurting our bottom line by reducing readmissions, so we need to overcome that to be able to give us the incentives to be even more aggressive around decreasing readmissions. So it's a matter of the incentives that have to be --

MILLER: But that sounds like the payment model. If the payment model changes so you're not losing money from readmissions anymore, whether that's global or episode payments, then that would give you the basis for making the investments yourself to be able to achieve those kinds of returns.

BENJAMIN: Well, I would think that's a big part of it. The payment model has to accompany all these changes to make the incentives for us to change the system.

MILLER: OK, so anything else the State should do besides give you money if you can't figure out how to make it work yourself? (laughter)

BENJAMIN: Well, I think it's in the change, in the payment systems that we really need to make sure that we're promoting quality and promoting integration.

MILLER: OK. So do you think the State should mandate better payment systems?

BENJAMIN: I think the State should be in a role facilitating better payment systems.

MILLER: What does that mean? Is that Pat's suggestion that they should do it in Medicaid and they should do it with their own employees, but...

BENJAMIN: So, again, where the State can control it and begin to model payment systems that will provide those incentives and Medicaid, the Group Insurance Commission, I think the State should take that active role.

MILLER: OK, Joe, what should the State's role be in all this?

BERMAN: I think the first step needs to be mandating primary care selection across all the insurances, and to help develop trust in the system. I know I sound like a broken

record here when it comes to the PCP managed care, but when you look at the PPOs and Medicare and Medicaid, without that PCP selection you can't get the patients into the system.

MILLER: What exactly does mandating PCP selection mean?

BERMAN: Well, many of our products here in Massachusetts do not require a primary care physician selection. Patients can decide where they're going to go, when they're going to go there.

MILLER: So but if they're mandated to select, are they free then to change, and how often can they change? Is it simply that they have to say, "I have a PCP and here's who he or she is," or what?

BERMAN: I think it is important that the primary care physician be involved in the patient's care for at least some period of time. With preferred Medicare, for example, patients have to select for, you know, the PCP --

MILLER: And if it's a lousy PCP are they stuck with them, or can they switch if they...?

BERMAN: Oh, I do believe that they need to have the choice, and this is where the transparencies come in of looking at quality measures and whatnot, but until you get the patient in the system, working with the primary care physician, having that primary care physician coordinate the care, I

don’t think you can get any of these models to begin to work.

MILLER: OK. Nancy, what should the State’s role be in getting us where we want to go?

KANE: Well, I think I tried to say it earlier, but I realized now I’m not a reactive panel. (laughter) You’re the reactor. (laughter) But I think the State --

MILLER: Uh oh, we lied on the agenda, didn’t we?

KANE: It’s OK, a little false advertising. I think the State really needs to set, to lead the way, and what we hope to see is a fair and value based payment system, and to monitor that to be sure that it is a fair --

MILLER: Lead the way, what do you mean by lead the way?

KANE: Lead the way, setting some rules out for what alternative payment systems should -- what kind of glide path we want to see, and what it should end up --

MILLER: Rules meaning mandates.

KANE: I’m sorry --

MILLER: Mandates?

KANE: Yes, setting up some rules. For instance, I mean, the fact that you’re looking at readmissions might have something to do with the fact that the federal government said readmissions are going to be penalized, and I think the State would want to be doing things like that, saying,

"Here's the rules, round one, round two, round three, targets, milestones." The special commission that I was on back in July of '09 listed a set of functions for an oversight committee that I think pretty fairly represent my view, because I helped form it, (laughter) form those recommendations, and I think that is that the State sets the rules. Helps the signal be unified, that yes, we want high value care at affordable price, we want the population's health to be better, and we want the population to be able to afford the health and have the rate of increase be within the rate of increase of people's ability to pay for that. Those are all targets. I don't want the State to micromanage the rates people pay, but I do want them to say that's, you know, if that rate is not based on some value that you can demonstrate then, you know, the way we've set it up now, that we might disallow that to the Division of Insurance, or we might otherwise have some way of trying to create transparency around that that makes it less viable. So I think the State needs to be the rule setter and a little bit of the umpire afterwards.

MILLER: And in your model, is that they're regulating what payers can pay to providers, or is that something about how, what the consumers are paying?

KANE: That's -- on insurance design? I don't know. I mean, I haven't really thought hard about whether, how the insurers should design the consumer incentives, and I think the State is not an insurer, so the, you know, the... I think you want to look more at what happens in the outcomes rather than all the little inputs that go into the outcomes.

MILLER: OK, Pat, you want to chime in on that?

GILLIGAN: Yeah. You sort of started with me on how do we get from here to there and then kind of changed it to how can the State be helpful, so a couple other things where they might be helpful --

MILLER: I wanted to know whether the State should sort of just get out of the way and watch you guys go at it, you know, once we agree on where we want to be or not?

GILLIGAN: Well, I started saying they can help us towards moving the [goal?] payments on the populations that they help manage, but the other thing is I do want to acknowledge that, you know, consolidation is an issue, and you raised this in your remarks, so even in a global payment environment we can't just all go to one provider, we need choice, and I think the State can be helpful to make sure that we have competition and different sets of providers. I also think they can help us to have alternative sites of

care and encourage those sites, whether it's urgent care centers or limited service clinics, or have other ways that primary care physicians can sort of extend out and use the system in a more efficient way.

MILLER: So it sounds to me like there is at least some agreement amongst all of you that the State should be trying to do some boundary setting around the edges, to try to sort of prevent the most egregious behaviors, to try to ensure consistent implementation of the things everybody agrees on with some disagreement maybe about how much flexibility in the middle. Some people would sort of like to have the State just do boundaries, and some people might like a little bit more push from the State to actually define what needs to be done. Is that a fair characterization of where everybody is, or would you disagree with what I just said? I see some nods. Say yes for the microphones, or no. (laughter)

M: Yes.

M: Yes, it's a fair characterization.

MILLER: OK. So we talked about this PPO thing, and that that's a barrier. Pat raised that. Joe wants them to be basically mandated to have a PCP so that they can be directed in their care. Is the PPO model, does it need to be changed? Outlawed? Is it really a barrier, or is this

something these different payment models, can they work within the PPO structure or what needs to change to make it work? Joe, you want to start?

BERMAN: Sure. I don't know how a global payment system will work with a PPO model.

MILLER: Because, why?

BERMAN: You are asking a physician, a primary care physician to take on the responsibility of managing that patient's care. You can't do that if the primary care physician isn't involved in the care. PPOs currently do not require patients to choose a primary care physician. They're self-direct --

MILLER: So if they chose a primary care physician, is that the biggest fix that needs to be made.

BERMAN: It's the first step.

MILLER: Or do they need to actually be gate keepers that (inaudible) the patient where you can go?

BERMAN: No, they don't necessarily need to be gatekeepers, but they need to be involved in the process. They're the ones trained in taking care of those patients, and to skip that vital first step I think is part of the problem. PPOs, you know, I don't think are evil. I don't think that they are the only problem in the health care system, but if we are saying that in five years we should have a global payment

system, I'm saying that the first step needs to be involving the physicians in the care.

MILLER: So you're talking about there may need to be some sort of different health plan product that isn't the typical PPO but isn't the typical HMO, that's some sort of a hybrid in the middle. Is that sort of what you're suggesting?

BERMAN: That's what I'm suggesting, and I think what you showed today, the model involving various levels of care management, I think is appropriate and would work.

MILLER: Pat, you said you had concerns about doing this in the PPO model. What's the biggest thing that happens in your PPO structure that troubles you about, or troubles the providers about moving to global payment?

GILLIGAN: Well, one thing we haven't talked about is attribution, so there are models out there to attribute members to a PCP without them selecting them, and those models are pretty robust, and we have run them, and I do think there is a way to align members in a PPO to a physician, and not necessarily a primary care physician but mostly primary care physicians.

MILLER: But if people pick their PCP the way Joe's suggesting, would that solve that problem?

GILLIGAN: That would be another way to get there, as well. And we have providers, by the way, who have looked at those models --

MILLER: Pull the microphone a little closer because you're looking --

GILLIGAN: Sure. Some providers would be willing to accept global payment on PPO using attribution, and even if the PCP didn't pick. The obstacles that I see are around the purchasers or the employers, and we have some education to do with them, and we've started to do that, but right now many large employers, when they buy fee for service, and if they're on a self-insured basis, they only expect to pay for services, and so the quality payments and some of the other things that you sort of need to build in to a robust global payment model is something that many large employers have just not wrapped their head around yet, and they are not necessarily thinking long term. They're thinking in the moment around when the (inaudible) is paid. The other thing is large employers want consistency for their employee population, and that includes across state lines, so if you think about a global payment, I mean, the product that the member or the employee is getting is much different in terms of the services they're getting, the focus on the quality. That's a very different experience.

It takes different education from the health plan, from the provider, from the employer, and that's very hard to do, because I don't see how we can sort of enforce that in Massachusetts and help larger businesses that have employees out of state.

MILLER: So we've talked a lot before about patients and about doctors and hospitals and insurance companies. You're saying we need to be doing something more directly to get employers and the self-insured employers engaged in this to be helping to move the market in this direction.

GILLIGAN: Yes, and I think some of that is starting with the focus on health and wellness in particular, but there's more work to be done there.

MILLER: But you're saying not just health and wellness, it's also trying to have them actually support the different payment models through the self-insured plans, as well as through your indemnity products.

GILLIGAN: Correct.

MILLER: OK. Is anybody else getting employers engaged here around the table at all? I guess that's a no. (laughter) So let me ask one final question, and then I'm going to take some questions from the audience and see if the gang over here has any questions -- or I'm not looking your way; do you guys want to ask questions? You do? OK, all right,

so one more question. So I think the big thrust of the, one of the major findings of the Attorney General's report was that a global payment wasn't controlling prices, wasn't controlling cost, and we can sort of debate about exactly why that was in the past, but again, looking forward to this future -- so in five or ten years, depending on which of you were asking, we should be having a dominant mode of global payment, but we don't want to get there and have a really swell dominant global payment model and end up finding that we're still spending more money than we had in the past. So what is the single biggest thing -- again, one thing -- single biggest thing that you think needs to be done in addition to having just global payment to be able to ensure that this actually supports lower or slower growing costs? Nancy?

KANE: Sorry. These one single biggest --

MILLER: That's why they pay you the big bucks, to be able to go first.

KANE: (laughter) Yeah. I think that the one single biggest thing to do anything I, you know, I actually don't believe in, because I think all of these things have to happen together or no one thing is going to fix it.

MILLER: Right. It's just that we don't have all afternoon, so I (inaudible) pick one.

KANE: I understand that you don’t have a whole time, and you already did it for us, so we don’t need to replicate that, but I think, you know, some -- a certain level of transparency would help a lot, both for consumers, as well as, I think, this is my idea about why you might want --

MILLER: But the concern is if we’re transparent about prices --

KANE: -- if I can -- let me just finish.

MILLER: OK, sorry.

KANE: I mean, I think having the State also play a role in clarifying, you know, what the price differentials are, because it’s very hard for any one party to put -- I don’t even know if the price that, you know, Blue Cross puts out is on the same bundle of services that the price that Harvard Pilgrim puts out. I mean, someone needs to sort of standardize how the data gets presented, and as the EG has done and (inaudible) has done, sort of present it in a way that looks, that sort of makes it credible. So I think the transparency is certainly part of it, and then the other piece is, I think, having both employers and their employees feel... Employers feel they can control cost just by cost shifting to the employee, and I honestly don’t think that does much, as you’ve pointed out. So how do you get both parties to sort of try to push value over just

reducing their share of the pie? And I think that's the other big piece, and that's where the transparency could help, if we really all thought we understood what the data meant and thought it was believable.

MILLER: And is transparency public transparency? Because the concern is, that people have raised, is that if we simply put out the difference in prices, then people will look and say, "Wow, that must be better care there because they're charging more," and --

KANE: Well, you need quality, and --

MILLER: So it's quality data, along with the cost?

KANE: I think so. Yeah, I think that's part of it. I think you need more than that, in a way, because just what happened with -- I think one of the thing that happened with BHCAG is that everybody --

MILLER: BHCAG, by the way, is the Buyers Health Care Action Group --

KANE: The Buyers Health Care --

MILLER: -- in Minnesota for those, an employer purchaser group.

KANE: Yeah, one of your examples is that, you know, for a while there was disparities in the cost and quality of the different providers, and everybody kind of ran to the same place, and then they all moved together, and so I think you

need to constantly be renewing what it is you're measuring, constantly pushing the end of the envelope for the measures that you want to improve on, and perhaps look a little bit more towards outcomes, toward population health measures, as well, which I think requires broader than a single payer, you know, a Blue Cross mentality, that, you know, there's a community out there, how's their health going.

MILLER: OK. OK, Pat, single most important thing to do to try to make sure that this all results in lower cost?

GILLIGAN: So I largely agree with Nancy that there is no single thing, but if we have to pick I also agree on transparency. I think creating more robust quality metrics will be important, and having transparency on both cost and quality is critical. I've had concerns in the past around transparency, on fee for service rates, because there hasn't been associated quality measures, and oftentimes that transparency sort of in the heat of the moment when the patient is sick and needs care, that sometimes the higher price is a badge of honor and they assume by that that therefore it must be a better quality. I have higher hopes for transparency around global payments -- what is the size of that payment -- coupled with good quality information, so that when members and employees actually choose their care you can actually look and say, "Well, is

this an expensive provider or not and what's their quality?"

MILLER: OK. Joe, single biggest thing?

BERMAN: The single biggest thing, I think, is investment in health information exchange to help all stakeholders in the care system to coordinate their care, reduce duplication, and to -- and through the information exchange you'll --

MILLER: So that will avoid people charging too much for their care.

BERMAN: Well, what you asked, what was the single biggest thing that we needed to do to reduce the cost in a global system, you didn't specify, you know --

MILLER: Amount that's charged or paid by the people who are paying for care. So how do we make sure that that actually is lower, assuming that we pay the right way? I'll give you three more seconds to think about it.

BERMAN: Well, no, I'll --

MILLER: OK.

BERMAN: -- defer to my esteemed colleagues here. Transparency has to be the only, you know... If what you're saying is how do you reduce the payment system, you do --

MILLER: How do you make sure that the payment levels are lower under whatever payment system it is that we're paying?

BERMAN: Right, and the built in assumption there is that we know what are the higher costs, what are the lower costs, and what the middle costs are, so you have to start that with a transparency system.

MILLER: OK, so three votes for transparency in data. Evan?

BENJAMIN: Well, when I listened to Susan Brown, the Assistant Attorney General, this morning, one of the things I took away from the report was that the failure of the global payments to control costs was really confounded by pricing, and I think one of the things we have to do is deal with the pricing issue. If we're going to lower costs I think we have to deal with leveling the playing field, and maybe we should be talking about the TME, the total medical expenses, which is risk adjusted, and look at TME across the state, and understand what the goals would be for TME and how we would look at TME across the state in all different providers.

MILLER: So I'm not quite sure what that means, though. Does that mean that somebody who is already spending a lot or a lot higher than others shouldn't be locked into their current spending level and should be expected to reduce it going into one of these models, or does that mean something else?

BENJAMIN: Well, we could look at what is TME, and one option is that you could level the playing field and create a TME goal for the entire state -- so in other words, trying to remove the negotiated prices out of the picture, and just talk about what should the goal be for total medical expenditures.

MILLER: OK, David?

POLAKOFF: Well, I'll certainly endorse the transparency that seems to be the dominant theme on the panel, but let me add a second factor that goes with that. I think as we create transparency on both cost and quality, we really need to go back to Joe's main theme of empowering the primary care physician to serve as a trusted advisor to the patient in evaluating the cost and quality data, adapting it to their circumstance, and making what is often a very difficult decision in an anxiety laden situation. Without that, I'm not sure that people will make optimal use of the cost and quality data and get us to the result we're looking for.

MILLER: OK. Let me ask some questions that came from the audience. So one question was -- I'll modify your question only slightly -- but fee for service, the questioner said "always be a part of our payment system," I'll say under the notion we just talked about will be there for a while, so the question is why aren't we focusing on a solution in

the fee for service model and what is the solution? So let me frame it the following way: so what do you think we need to be doing with fee for service? Do we just sort of let it alone until we get global payments in place, or should we be trying to fix fee for service in some fashion in the short run? Nancy?

KANE: Well, a lot of the fee structure is based off, certainly physician fee for services, is based off the Medicare payment RBRBS system, and Medicare itself recognizes it's terribly flawed and is trying to work with it to make it a little more remunerative to be a primary care doctor and maybe less remunerative to be a radiologist, but I think, you know, they're going to tweak that until the cows come home and they're never going to catch up with all the possible ways that that system can be gained if the incentive is to do more and get paid more, and Medicare recognizes that, and I think that's why we have Medicare Center for Innovation trying to create new payment models, because if you... But I do think fee for service will be with us for a long time, because even though you pay global capitation to a system, within that system there may well be fee for service distributions of the resources, depending on, you know, what they're taking care of. So I do think it would be great to get the fee

for service system to be tweaked into a less -- what's the word? It's a little bit on the one sided towards specialty and intervention care and not enough on evaluation and management, but I just want to remind you that back in 1992 or '3, whenever it was Bill [Shall?] came out with the ideal resource based relative value system, it was meant to redistribute resources toward primary care and away from specialists. Ten years later into implementation there's been no change in the way it was pre-'93, so you can tweak all you want to try to fix these little payment systems, you know, at the unit of service level. You cannot keep up with the level of change in both, you know, the way they're updated, the way they are defined and weighted, what happens when new technology comes... You just can't keep up. So it's far better to have the providers face the same incentive as everybody else, which is it has to stay affordable, than try to play games and tweak fee for service ad infinitum, because we've tried that, and Medicare's been trying it for 30 years.

MILLER: Boy, they sure have. Any other quick thoughts anybody wants to share in terms of a fixed to fee for service? Pat?

GILLIGAN: Yeah, I think fee for service will be around for a while, and some of the market changes are helping that

already. One is we can be in a world have having some global payments and fee for payments. That's where we are today. And by having the global payments we are incenting primary care physicians and those that actually have the global payment to pick the right fee for service provider, and that is changing referral patterns, and I think will change the negotiations over time. Engaging the members through products does the same thing -- by adding to your products, the members realizing that they may not want to pay more to get the same service to go downtown or to an academic medical center will be shifting fee for service expectations of providers.

MILLER: So here are two questions from folks in the audience which are related so I'm just going to ask them jointly. The first question is if the AQC or global budget for my care depends on which doctor I sign up with -- i.e., there's more money for my care with a doctor at Atrius than for a doctor at Brockton Hospital -- then don't global payments incentivize patients to choose doctors at places with the biggest budgets? And then the other question was, so how do we address the fact that only the already large, profitable institutions will have the resources, knowledge, and know how to contract to their advantage, and related the smaller hospitals [are?] letting themselves be bought,

the emerging large networks will have more market power or potential to drive up prices. So this issue of we're sort of paying people differently does not mean that for the same thing, doesn't that, in the short run doesn't that drive people to the more endowed facilities, and doesn't that allow the more and better endowed facilities to put the smaller providers out of business? And is that something that we need to address? So I'll start with Pat because that was sort of a question of the AQC to start with, but I'll see what others think about that.

GILLIGAN: Yeah. Well first, in terms of the different budgets that are out there, we did consciously start providers where they were, and that was a very important decision we made back in 2008 --

MILLER: Starting them meaning that they were at different levels of expenditure per patient and they were getting, they were started at that level.

GILLIGAN: Correct, correct. And I understand the notion that maybe we'd want to have a set PMPM or start everyone at the average, but to do that you'd almost have to have mandatory participation in some way, because if you ask people to volunteer to come into a payment method and then pay at the average, if you're above the average you're not going to sign up and if you're below the average you will sign up,

and the total cost will go up significantly. We do see those TMEs coming together over time. It's going to take many, many years to get there. In the meantime, I don't know that from a patient perspective that they would see more resources being available to them with a provider that has a higher budget than lower budget. Much of that is geographically oriented. It could be based on the referral hospitals that they used. I'd go back to my earlier comments around quality, and think we should get to a place where we can all compare on quality and pick our doctor based on quality, and if we're doing that and seeking high quality for ourself and have a payment model that's going to incent them to also be efficient, that would give us movement in the right direction.

MILLER: And how about the notion that somehow if we're only doing things that big institutions can do that that is going to accelerate the trend towards having smaller entities go out of business?

GILLIGAN: Yeah, it's a really delicate balance. We would certainly acknowledge that in a global payment system you need to have a large enough group of physicians to manage the population. You need a large enough population to do that. On the other side, we don't want to get to the place where there isn't choice in providers, and that is a

difficult balance, and one that I suggest that maybe the State could be helpful in.

MILLER: Joe, you're a small provider. As you said that you thought we could get the global payment, that was a good idea, so does that mean that you're going to sell yourself off to somebody else to do that, or are you going to be able to do it on your own?

BERMAN: No, Acton Medical has participated in risk contracts for 30 years, and we've done so successfully. You know, the question of whether -- so, no, we won't sell ourselves off to a larger entity. I think that we are able to manage in a global payment system very well. I mentioned earlier that we are a Level 3 certified medical patient-centered medical home. We also, through our risk contracts, provide services that you wouldn't find in a fee for service environment. The start of this question really was do patients receive additional services with that higher rate. I think in many cases it is the case. We provide diabetes education, asthma education, mental health coordination, a bank of triage nurses, referral management department, services... The infrastructure for global payments to manage care effectively, we provide that infrastructure. It's not directly compensated or reimbursed, and all of our patients benefit from that.

MILLER: Do you feel disadvantaged by these other big providers getting paid more?

BERMAN: In some ways, I do feel that our negotiation power is lessened because of our size, but I think --

MILLER: Are you losing patients because of that, do you think?

BERMAN: I think we lose patients in the PPO model, not to hammer that one too much. Yeah, I think we lose certain patients --

MILLER: I commend you for being on message consistently throughout (inaudible). (laughter)

BERMAN: Yeah, I do believe we lose certain patients. I believe that patients who self-direct, who are not coordinating their care with the primary care physicians do equate these higher cost facilities as higher quality facilities, without the opportunity to bring them in the system to help, to let us help coordinate the care, to refer to the community hospitals when appropriate. I do think that we lose patients that way, and it's somewhat -- it is a disadvantage for us.

MILLER: OK. So the man in the front row is telling me that we are out of time, so let me thank the panel for their testimony, and maybe you all want to give them a round of applause. (applause)

Seena Perumal Carrington

And thank you, Harold, for moderating the panel!

Harold Miller

And I’m going to turn it back over to Seena to tell us what’s happening next.

Seena Perumal Carrington

Thank you again, Harold, appreciate it. And thank you, panelists, for your comments and your time today.

[irrelevant audio omitted]

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